FEE-BASED/ COLLEGE FOR KIDS ADMISSION & REGISTRATION FORM

- Complete and sign this form. ONLY ONE FORM PER STUDENT. Form may be duplicated.
- **Mail or drop in person**: Allan Hancock College, Community Education - Bldg. S, 800 S. College Dr., Santa Maria, CA 93454-6399
- **Fax**: 805-352-1046
- Payment is accepted in the form of check, money order, or credit card. Cash is only accepted with walk-in registration. Do not send cash in the mail. Make check(s) payable to: AHC Community Education

Student's/Child's Legal Name: _____ Birthdate: _____Gender: ____
Street Address: _____City: _____ Zip Code: _____
Home Phone No.: _____ Cell Phone No. _____
Email Address: _____
Student's Signature: _____ Date: _____

College for Kids Only:

Where parents can be reached in case of emergency:
Mother (name) _____ Address: _____
Phone: _____ Alternate Phone: _____
Father (name) _____ Address: _____
Phone: _____ Alternate Phone: _____

Parent's Email Address(optional): _____

In the event of emergency, notify the following person if parents cannot be reached:
Name: _____ Phone: _____

(Child's Name) _____ has my permission to participate in the Allan Hancock College (AHC), College for Kids program. The undersigned agrees to accept full responsibility for delivering the student to the class at the appointed hour and for picking up the student at the conclusion of each session. The undersigned agrees to hold Allan Hancock College and any officer or employees thereof harmless from any claim for injury to the above-named minor arising out of or in any way connected with AHC College for Kids program. The college, its officers or employees, will not be held responsible in any way for the health, safety, or welfare of the student while in route to or returning from any class or activity offered as a part of the AHC College for Kids program. The undersigned agrees to permit photographs to be taken of this student enrolled in the AHC College for Kids program to be used for promotional purposes.

I, the undersigned parent/guardian of _____ (Child's Name), a minor, age ____, do hereby authorize Marian Medical Center or Lompoc Hospital as an agent for the undersigned consent to any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the medical staff when such diagnosis or treatment is rendered at said hospital.

Parent/Guardian Signature: _____ Date: _____

CRN	FEE	COURSE TITLE	DAYS/TIMES	INSTRUCTOR

METHOD OF PAYMENT:

☐ **CHECK (*Do not mail cash*) *OR*** ☐ **CREDIT CARD** Select one: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

*If paying by credit card, all credit card information (below) **MUST** be completed.*

Credit Card #_____Exp. Date _____Security Code _____ TOTAL FEES $_____

Print Name _____ Authorizing Signature _____

Credit Card Street Address (number only) and Zip _____