

FREE After School Tutoring/Homework Assistance

Do you like to have extra support from teachers and fellow students while completing independent practice? Are there a lot of prerequisites on your ALEKS path, and you need additional time and help to fill in those learning gaps? Maybe you just need a quiet space and some structured time to work on your homework before you go home to your family. This program is also a great option for students who do not have access to reliable internet at home.

Requirements: Students will sign in each day and should know what they are there to work on, as well as exactly how they are going home (parent pickup or activity bus stop). Each student who attends the tutoring program must bring in a completed enrollment form (including the emergency contact section on the back).

- Who: All Harns Marsh Middle School students
- What: FREE After School Tutoring/Homework Assistance
- Where: HMMS Media Center
- When: 4:10 - 5:15 every Tuesday, Wednesday, and Thursday (except for school holidays, early dismissal days, and teacher workdays)
- Dismissal: Students will be dismissed at 5:15 pm and can either be picked up or ride the activity bus.
 - Parents picking up their child should be in the parent pickup line by 5:15 pm.
 - Students can ride one of the two activity buses (these buses have limited bus stops, please see bus routes below and indicate which stop the student is to use).

Student name _____ Grade _____ ID Number _____

_____ WALK/BIKE: My child has permission to walk or ride their bike home.

_____ PARENT PICKUP: Someone will pick my child up at 5:15 pm. (Students that are not picked up by 5:30 will go to the fee-based program and be charged a registration fee plus the daily rate.)

_____ ACTIVITY BUS: My child will ride the activity bus. Their stop will be _____.

Lehigh Bus 1738

5:30 PM RICHMOND AVE N & WOODBURN
DR/WINDERMERE DR
5:43 PM COUNTRY CLUB PKWY & KINGSTON ST
5:48 PM BELL BLVD & GRANT BLVD
6:02 PM EAST LEE COUNTY HIGH BUS RAMP
6:11 PM COLUMBUS BLVD & BELGRAVE ST
6:34 PM VETERANS PARK ELEM
6:38 PM ARTHUR AVE IN FRONT OF LEHIGH ACRES
MIDDLE
6:41 PM G WEAVER HIPPS ELEM & TAYLOR LN
6:51 PM 40TH ST SW & SUSAN AVE S
6:53 PM 40TH ST SW & HANNA AVE S
7:01 PM LEONARD BLVD S & GREGORY AVE S-NORTH
SIDE
7:06 PM GRIFFEN DR & GATEWAY ELEM
7:17 PM TREELINE AVE & TREELINE ELEM
7:29 PM FORUM BLVD & REAVELLO BLVD-DOOR SIDE
THE COLONNADE AT THE FORUM

Fort Myers Bus 1705

5:28 PM 68TH ST W & JUNE AVE N
5:49PM SUNSHINE ELEM
6:06 PM LEHIGH SENIOR HIGH
6:21 PM TORTUGA PRESERVE ELEM BUS RAMP
6:32 PM RIVERDALE HIGH & RIVERDALE HIGH
6:44 PM ROYAL PALM PARK RD & LAVONNE
AVE-SHANDLER HALL
6:48 PM EDGEWOOD AVE/EDGEWOOD ACADEMY
6:53 PM JAMES STEPHENS INT ACADEMY
6:57 PM TICE ELEM IN FRONT OF SCHOOL
7:11 PM ORANGE RIVER ELEM RAMP
7:20 PM SAMVILLE RD/WILLIAMS RD-BAYSHORE ELEM

Parent signature _____

FILL OUT COMPLETELY - SIGN - RETURN TO SCHOOL

Teacher: _____
 Room/Teacher: _____
 Date: _____
 Medical Conditions- SEE BELOW

STUDENT EMERGENCY AND HEALTH INFORMATION

THIS INFORMATION IS CONFIDENTIAL, BUT MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL.
 Custody Restrictions - Current Court Ordered Documents Required

Student's Full Legal Name: _____ ID #: _____ DOB: _____

Address: _____ Home Phone: (_____) _____

Parent: Natural / Step / Foster (please circle one)
 Name: _____
 Cell Number: _____
 Place of Employment: _____
 Occupation: _____
 Phone at Work: _____

Parent: Natural / Step / Foster (please circle one)
 Name: _____
 Cell Number: _____
 Place of Employment: _____
 Occupation: _____
 Phone at Work: _____

Parent: Natural / Step / Foster (please circle one)
 Name: _____
 Cell Number: _____
 Place of Employment: _____
 Occupation: _____
 Phone at Work: _____

MUST BE FILLED OUT - Person(s) who will care for student in case neither parent can be reached. (only the people listed may pick up your child with proper identification):
 Name: _____ Relationship: _____ Phone: (Home) _____ (Work) _____ (Cell) _____
 Name: _____ Relationship: _____ Phone: (Home) _____ (Work) _____ (Cell) _____

Label all children in family in order of birth:

Name (first and last)	Age/Sex	Living at Home	Grade/Teacher	School
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please check all medical conditions that apply to your child: (Check Box & Circle if Required)
 ADD/ADHD Asthma Migraine Hearing Loss Glasses/Contacts
 Allergies: Food/Latex/Insects/Environmental Specify _____ Medication Epi-pen
 Diabetes/Type _____ Blood Testing at School? Y or N Insulin? Y or N
 Heart Disease/Kidney Disease _____ Surgery? Y or N Medication? Y or N
 Seizure/Type _____ Medication? Y or N
 Any other condition requiring observation or medication: _____
 DOCTOR'S NAME: _____ PHONE: _____

Parent's Statement: I accept responsibility for notifying the school of any changes of home or business address or phone number or any change in health status of my child. Students may receive State specified health services and vision, hearing, weight, BMI and scoliosis screening, if the vision screening shows a need for a follow-up vision examination, and if your child is eligible, Florida Heiken Children's Vision Program, Florida's Vision Quest or other licensed optometrist may provide a RO-COST vision examination by a licensed optometrist, which may include dilation, refraction, and glasses if prescribed. I agree to a mutual exchange of information between the Florida Heiken Children's Vision Program, Florida's Vision Quest, referring providers, DOH and my County Public School of any and all necessary information to enable my child to receive services, and I agree to release and hold harmless the County School Board, Miami Lighthouse for the Blind & Visually Impaired, Florida Heiken Children's Vision Program, and Florida's Vision Quest providers from any and all responsibility and liability for any injury or claim resulting from my child's participation in the Florida Heiken Children's Vision Program or Florida's Vision Quest. Student may be exempted from any of these services if parent or guardian requests such exemption in writing. In the event of serious illness or accident and I cannot be immediately contacted, I give permission to have my child transported by ambulance or other conveyance to a doctor's office or hospital for immediate attention, and I assume responsibility for payments of same. In case of an accident or illness where immediate treatment is not needed, but where my child is unable to remain in school, I request the school to contact me. If I am unable to be reached, I request that one of the persons listed above be contacted to care for my child until I can be reached. These persons have permission to transport my child. I understand that certain of my child's educational records will be shared with District health care partners as needed to provide and evaluate health services and that certain of my child's medical treatment records created by health care personnel at school may be shared with school officials who have a legitimate need for access.

Signature of Parent or Guardian _____ Date _____
I understand that the information on this form will be the official student directory information.