BOOKING FORM

Please complete and return with payment.

Monday 6th July to Friday 10th July 2009

Name of Child/s_____ Age_____ Grade_____

_____ Age_____ Grade_____

_____ Age_____ Grade_____

School Child/s Attends_____

Parent's/Guardian's Name _____

Address _____

_____Post Code_____

Home Telephone: _____

Work No: _____ Mobile No: _____

Relative/Neighbour/Friend Name: _____

Telephone:_____

Does your child suffer from any condition we should be aware of? Yes / No
If Yes, give details:

PLEASE BOOK EARLY FOR FULL WEEK PLACES!

Day / date	Option 1, 2, 3BC or 3AC	Cost

Option **1**		@ $42.00 per head	
Option **2**		@ $54.00 per head	
Option **3**		@ $48.00 per head	
Option **1** Full Week @ $199.50 per head			
Option **2** Full Week @ $256.50 per head			
Option **3** Full Week @ $228.00 per head			
Add $5 if paid after 19/06/09			
Total Amount Due			

Consent to Medical Attention
I authorise the teacher in charge of the Holiday Program to consent, where it is impracticable to communicate with me, to the child receiving such medical or surgical treatment as may be deemed necessary.

Signed_____ Date _____

Tick here for a Child Care Benefit Receipt. ☐

Parent name for receipt:

_____

Future Holiday Program Booking Forms may be emailed, posted or faxed. Please tick your preference.

Mailed (as above):☐ Email Address: (Please print clearly) _____

Facsimile No:_____

How did you learn about our Holiday Program?
Local Library Friend School Newsletter Website Mailout Teacher Radio ABC

Post to:

Hands On Science
PO Box 619
North Balwyn 3104

Fax to:
9855 1193

Email to:
robjudd@internode.on.net

Payments will be accepted by:
Cheque, Money Order, Cash or **EFT** (Deadline is Friday 26th June)

For EFT payments:
Please quote: BSB: 704-191
Acc No: 154410

Acc Name: T/As Hands On Science

Tag with: Your surname

Payment made by:

Cheque ☐ Money Order ☐

EFT ☐ Cash ☐

Payment or proof of payment must accompany Booking Form.

Receipts of payment will be issued within 4 business days. Contact Robyn if you do not receive confirmation.

Sorry no cash refund except with a medical certificate. Administration costs will be deducted.

OFFICE USE ONLY:

Date: _____ Receipt No: _____ Amount:_____

Date: _____ Receipt No: _____ Amount:_____

Date: _____ Receipt No: _____ Amount:_____

C C R No: _____

M/O Ent: _____

Prog Ent:_____