



# Nova Elm Academy (NEA)

## Tahfiz Ul Quran Registration Form (Monday – Friday 8:00 AM – 12:30 PM)

### Tahfiz Ul Quran Tuition

- \$325.00 Monthly tuition
- 15 % - 2<sup>nd</sup> Child discount
- 30 % - 3<sup>rd</sup> Child discount
- 50 % - 4<sup>th</sup> Child discount
- \$100.00 One-time Tahfiz-Ul Quran Reg.
- 8:00 AM – 12:30 PM

### Student Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Gender:    Male    Female

### Parent / Guardian Information:

Name of Father: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Name of Mother: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

### Emergency Information:

Contact: \_\_\_\_\_ Relation to Student: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Allergies: \_\_\_\_\_ Medication: \_\_\_\_\_

Medical Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Nova Elm Academy (NEA) Liability Waiver

As the parent/legal guardian of the minor listed above, I hereby grant permission for the student(s) to participate in all the activities of NEA programs. I assume full responsibility for any injuries or damages which may occur to this student(s), in, on or about the premises of NEA, or arising out of its activities, and do hereby fully and forever release and discharge NEA, its employees, staff, and volunteers, from any and all claims, demands, rights of action, or causes of action, present or future, whether same, be known, anticipated or unanticipated, resulting from or arising out of the student(s) participation in the programs and activities of the aforesaid school. I further grant permission to provide emergency first-aid and/or hospitalization to the student(s) listed above in case of injury or illness as deemed appropriate by the school or a physician. Any medical expense incurred for medical treatment shall be my responsibility. I also understand that it is my responsibility to make the office aware of any medicine the child is taking.

I also understand that payment is due at time of registration and is non-refundable.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

### For Office Use Only

Payment Received by \_\_\_\_\_ on \_\_\_\_\_

Payment Type

1. Post Dated Checks # \_\_\_\_\_ Payment from \_\_\_\_\_ to \_\_\_\_\_

2. Credit Card

Name on card \_\_\_\_\_ Number \_\_\_\_\_ Expiration date \_\_\_\_\_ CVC \_\_\_\_\_