

WESTERN PENNSYLVANIA  
**LEARNING ACADEMY**

presents

**PRACTICE  
MATERIALS  
PROVIDED!**

**SAT<sup>®</sup>**

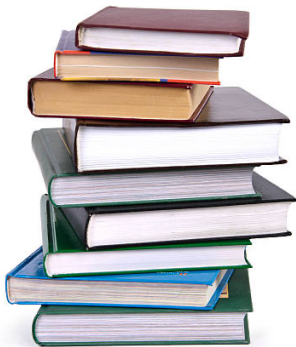
**BOOT  
CAMP**

**\$100**

**Sunday, October 30, 2022**

**Noon – 5 p.m.**

**Fox Chapel Area High School LGI**



- Test taking and time management tips
- Intensive grammar & usage skills review
- Intensive math skills review
- Critical reading skills and strategies
- Practice drills with actual test questions
- Experienced and highly-trained instructors

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Email: \_\_\_\_\_ School District: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Email: \_\_\_\_\_

*Please make checks payable to Fox Chapel Area School District (FCASD).*

*Submit check and completed registration form (front and back)  
either in person (Fox Chapel Area High School room 168) or via mail to:*

Lisa Gibson, Director  
Western PA Learning Academy  
Fox Chapel Area School District  
611 Field Club Road  
Pittsburgh, PA 15238

The well-being of any child is a parental responsibility. In an emergency, every effort will be made to contact a parent/guardian. Please list two persons who can arrange transportation and care for your child when you are not available.

Relative or Friend: \_\_\_\_\_ Phone: \_\_\_\_\_

Relative or Friend: \_\_\_\_\_ Phone: \_\_\_\_\_

# WESTERN PENNSYLVANIA LEARNING ACADEMY

## SAT Boot Camp Program Permission Form

Student Name: \_\_\_\_\_

I, \_\_\_\_\_ give permission for my child to attend the assigned date of the Western Pennsylvania Learning Academy's SAT Boot Camp. In the event of an emergency, if treatment is required and parents/guardians cannot be notified immediately, I give consent for emergency treatment and transport to the nearest emergency room.

Does your child have any health concerns that would hinder participation in the field experience? \_\_\_\_\_ No \_\_\_\_\_ Yes. If yes, please complete the following:

Please indicate if your child has any of the following health concerns:

_____ Asthma	_____ Inhaler needed
_____ Life-threatening allergy to bee sting	_____ EpiPen
_____ Life-threatening allergy to food	_____ Benadryl needed
_____ Seizure disorder	_____ Diabetes
_____ Allergy to _____	Other _____

Emergency Treatment (if needed): \_\_\_\_\_

Health Insurance: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

*My signature confirms that my child has permission to participate in all activities on the specified dates. Permission is also granted to share this information with appropriate academy personnel.*

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_