

Leman Academy of Excellence

AfterBell

2025 - 2026

Enrollment Packet



Dear Leman Family,

Congratulations on your acceptance into the 2025-2026 Leman Academy AfterBell Program! We are excited to welcome your scholar on our Marana campus. To complete the enrollment process, please submit the following within 14 days of this letter:

- A completed Emergency Information Card
- A copy of your scholar's current immunization record
- A Tuition Express payment form with **EITHER** Section A or Section B completed.

Your scholar's enrollment is not complete until each of these items are received. You may submit them via email to maranaafterbell@lemanacademy.org, in person at the AfterBell desk, or to our Leman Marana Front Office staff.

For any questions about AfterBell, please do not hesitate to reach out. Our staff cannot wait to partner with you this upcoming school year!

In caring,

Tayler Markle
Leman AfterBell Director – Marana
tayler.markle@lemanacademy.org
(520) 639 - 8080 ext. 3100



LEMAN ACADEMY

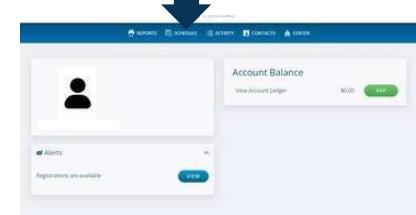
Afterbell Scheduling



Scheduling in Afterbell is a breeze with our user-friendly online system. You can access your account 24/7 to manage payments, **schedules**, and program information.

LOGIN AT
MYPROCARE.COM

1 SELECT YOUR SCHOLAR



2 SELECT SCHEDULE

Located in the top tool bar

2



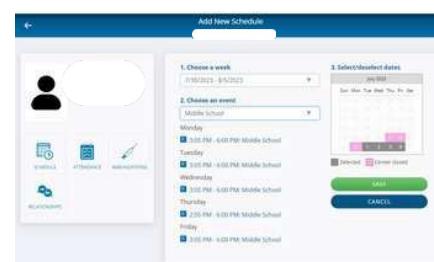
3 SELECT QUICK VIEW

Green Button

4

SELECT ADD ITEMS

Green Button underneath the calendar



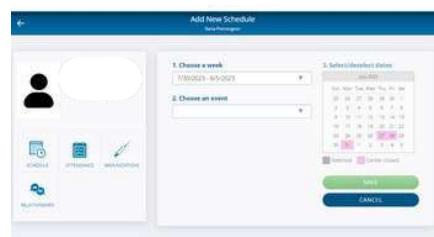
5 CHOOSE A WEEK

From the drop down select the week you are scheduling for.

6

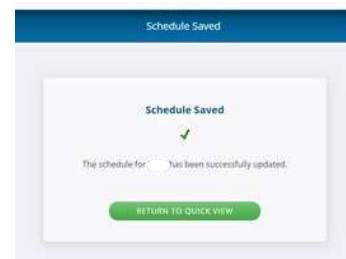
CHOOSE AN EVENT

- From the drop down select your scholars grade
- Unselect any days your scholar will not attend that week.
- Click Save (Green button underneath the calendar)



Scheduled Saved Confirmation!

You can click return to quick view and view the week that you have scheduled by checking out the highlighted squares on the calendar. For the following weeks on your list, repeat the steps. You will need to do this for each scholar if you have multiple. You can plan up to six weeks ahead, and if needed, make changes up to four days prior to the scheduled week.



If you need help or have any question please reach out!

Marana Campus: Tayler Markle - 520-639-8080 ext. 3100 - tayler.markle@lemanacademy.org

East Campus: John Houchin - 520-526-0481 - john.houchin@lemanacademy.org

Arizona Department of Health Services
Bureau of Child Care Licensing
Emergency, Information and Immunization Record Card

Child's Name:	Date Enrolled:	Updated:
Home Address (#, Street, City, State, Zip Code):		Date Disenrolled:
Home Phone:	Date of Birth:	Sex: <input type="checkbox"/> male <input type="checkbox"/> female

Parent or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

Parent or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	Name:	Contact Telephone Number:
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*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety.

In case of injury or sudden illness, I request that this individual be called first:	
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The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. yes no

Telephone Authorization Code (optional): _____

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:

www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

<input type="checkbox"/>	Copy of current official documented immunization record attached
<input type="checkbox"/>	Religious Beliefs exemption form signed by parent/guardian attached
<input type="checkbox"/>	Medical Exemption form signed by physician and parent/guardian attached
<input type="checkbox"/>	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

Is child allergic to food or other substances? **No** **Yes**

If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:

Is child usually susceptible to infections and if so, what precautions need to be taken? **No** **Yes**

If yes, list precautions:

Is child subject to convulsions and what should be our procedure if one occurs? **No** **Yes**

If yes, specify procedure:

Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? **No** **Yes**

If yes, list precautions:

Additional comments:

Other special instructions:

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	SIGNED Name:	DATE:
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Automated Payment Processing

Safe. Convenient. Easy.



We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name	Phone #		
Cardholder Address	City	State	Zip
Account Number	Expiration Date		
Cardholder Signature	Date		

SECTION B (Bank Account)

Your Name	Phone #			
Address	City	State	Zip	
Bank or Credit Union Name	Bank or Credit Union Address	City	State	Zip
Routing Transit Number (see sample below)	Account Number (see sample below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	
Authorized Signature	Date			



FOR OFFICIAL USE ONLY

Date Received
Employee Signature

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