STEINMETZ ACADEMIC CENTRE
Dr. Madon, Principal
Tutoring Starts Monday September 29th
Please complete the contract
Email to slofton@cps.k12.il.us
Or fax to 534-3151

GRADE RECOVERY CONTRACT OF SERVICES

I am requesting that my child be placed in Steinmetz' Grade Recovery Program. My child will be attending on the following day(s):

Monday Tuesday Wednesday Thursday

The program runs from 2:35 until 4:00 p.m. Services begin the week of 2/11/08. The student will report to room 222. My child will attend for the following:

Algebra World Studies English I Reading in the Language Arts

Biology Health Other course:_____

List names of teacher(s) for the above class(es) for copy purposes (refer to progress report for names):
1. 2. 3.

Should my child not be in attendance, I will be contacted and an absence will be recorded. The regular classroom teacher will be apprised of the student's progress and attendance in the Grade Recovery Program.

If my child is absent, please contact me at (cell phone#) _____ or at

_____.

I understand and agree to the above.

_____ _____
Parent PRINT name clearly Parent Signature

_____ _____
Student PRINT name clearly Student Signature

_____ _____
Teacher completing contract Teacher Signature

_____ _____
Program Director Program Director Signature