

Tues: _____ Wed: _____ Thurs: _____

Registration paid: _____

Mother's Day Out Registration Card

Name: _____ Age: _____ Birthdate: _____
Address: _____ Phone: _____
City: _____ Zip: _____
Parent's name: _____ Daytime Phone: _____
Cell Phone: _____
E-mail address: _____

Allergies and special medical problems: _____
Hospital Insurance: yes no Insurance company: _____
Policy Number: _____
Emergency phone numbers: _____
Person who will pick up the child at the end of the day: _____

I, _____, the legal guardian of _____ consent to my child participating in the Hope Church Mother's Day Out program. I hereby release Hope Church and the directors thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the child-participant while the said child is participating in the above described activity.

I also grant permission for my child to be taken to a doctor or hospital and hereby authorize medical treatment rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital, including but not in limitation to emergency surgery or medical treatment, and assume the responsibility of all medical bills, if any.

Parent / Legal guardian

Date