

PARENT CELL PHONE: _____

**HOLY ROSARY BI-PARISH SCHOOL
AFTER-HOURS PROGRAM
CHILDCARE WAIVER AND MEDICAL INFORMATION**

CHILD NAME: _____ DOB: _____ AGE: _____

ADDRESS: _____ HM PHONE: _____

FATHER NAME: _____ WK PHONE: _____

MOTHER NAME: _____ WK PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

(other than parent)

EMERGENCY CONTACT: _____ PHONE: _____

(other than parent)

SPECIAL NOTES REGARDING YOUR CHILD (i.e. medications, allergies): _____

PHYSICIAN: _____ PHONE: _____

DENTIST: _____ PHONE: _____

HEALTH INSURANCE CARRIER: _____

GROUP NO.: _____ POLICY NO.: _____

I agree to assume responsibility for instructing my child to follow directions and instructions given by the child care provider(s) in charge. I understand that if my child misbehaves he/she may be removed from child care.

I, the undersigned, am the parent of the above named child and I agree, in taking advantage of this child care service, to release and hold harmless Holy Rosary Bi-Parish School, its officers, trustees, agents, and employees, from any and all claims, demands, suits, costs and charges in connection with or arising out of the child care service including but not limited to, accidental bodily harm or injury to my child.

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the Holy Rosary Bi-Parish School child care coordinator or person in charge to arrange for routine or emergency medical care and treatment necessary, including ambulance transportation, to preserve the health of my child.

I acknowledge that I am responsible for all charges in connection with any emergency and medical care needed during the time that my child is in childcare.

SIGNATURE OF PARENT _____ DATE _____