

***SPECIAL INSTRUCTIONS: Receipt Requested _____ Billed _____

Name of Child _____ Age _____ Date _____ Time _____

Notify in Case of Emergency _____ Phone _____

Parent may be reached at _____ Phone _____

Person picking up the child/children _____ Their Phone _____

In case of emergency medical care, I give my permission to be treated and minor first aid given and/or transported to Passavant Hospital for treatment. I also give my permission for the staff to give a prescription or non-prescription drug that I wish to be administered to my child.

FEE: \$4.25/hour (over 2 years) \$4.70/hour (12-24 months) \$4.80/hour (6 weeks to 12 months)

Parent's Sign In _____ Parent's Sign Out _____

EXPECTED TIME OF RETURN	ACTUAL TIME OF RETURN	AMOUNT PAID	NAP & TIME	LUNCH
_____	_____	_____	_____	_____

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