



2010 Wee Summer Weekly Registration Form

PLEASE COMPLETE ONE FORM PER CHILD

CHILDREN 8 WEEKS THROUGH THOSE WHO HAVE NOT YET ENTERED 1st GRADE ARE ELIGIBLE.

Child's Name: _____

Date of Birth _____ Age as of 7/1/10 _____

Parent's Name: _____

Address: Street _____ City _____ Zip Code _____

Phone: (home) _____ (mobile) _____ (email) _____

Sessions are offered for one or two days per week.

The two-day sessions are Mon/Wed or Tues/Thurs.

The hours are 9:30 a.m. - 1:00 p.m.

HPPC members \$22/day/child *** Non-HPPC members pay \$30/day/child.

IN OFFICE REGISTRATION: PAY AT TIME OF REGISTRATION

ONLINE REGISTRATIONS: DO NOT PAY UNTIL CHILD CARE NOTIFIES YOU OF ACCEPTANCE IN THE PROGRAM.

EMAIL COMPLETED REGISTRATION AND EMERGENCY MEDICAL FORM TO CCRESERVATIONS@HPPC.ORG

HPPC MEMBER \$22.00 x # _____ Days = Total Due \$ _____

NON-HPPC MEMBER \$30.00 x # _____ Days = Total Due \$ _____

PLEASE INDICATE THE DAYS YOUR CHILD WILL ATTEND:

<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>
June 28 _____	June 29 _____	July 1 _____	July 2 _____
July 05 <u>CLOSED</u> _____	July 06 _____	July 07 _____	July 08 _____
July 12 _____	July 13 _____	July 14 _____	July 15 _____
July 19 _____	July 20 _____	July 21 _____	July 22 _____
July 26 _____	July 27 _____	July 28 _____	July 29 _____

NOTE: FEE CANNOT BE REFUNDED IN CASE OF CANCELLATION

OFFICE USE ONLY

Amount _____ Date Rec'd _____ CK#: _____ Cash: _____

2010 Emergency Medical Information Form

In order to protect your child in case of a medical emergency, please provide the following information.

1) Child's Name: _____

DOB _____

2) Parent's Name: _____

Telephone numbers where you may be reached:

Home: () _____

Business: () _____

Mobile/Pager: () _____

Child's Physician: _____

Telephone #: () _____

Insurance Information: _____

3) If parent cannot be reached, we will try to contact another relative or friend.

Name: _____ Relationship: _____

Address: _____ Telephone #: () _____

Name: _____ Relationship: _____

Address: _____ Telephone #: () _____

PLEASE LIST ANY ALLERGIES: _____

4) In the case of sudden illness or accident to _____
I hereby authorize a representative of the Highland Park Presbyterian Church to refer the child to the above mentioned physician.

5) In the event of injury, a representative of the HPPC is free to transport the child to the following preferred hospital.

_____ Hospital

_____ Signature of Parent or Guardian

_____ Date

Publicity Release Form (Optional)

The undersigned, being the parent(s) or guardian(s) of _____ do hereby give permission for him/her to be featured in any and all of Highland Park Presbyterian Church's promotional materials. I understand and consent to the use of my child's name and/or photograph to be used in HPPC's promotional materials including, but not limited to newsletters, brochures, video, and the Church's website.

_____ Signature

_____ Date