

Grace Ev. Lutheran Church and School
262-251 7140 Ext. 109
SUMMER SIZZLERS
Registration Form



Student Name (First/Middle/Last) _____

Grade Entering _____ School Year _____

Address _____

City _____ State _____ Zip _____

Parent(s) Name _____

Home Phone Number _____ Email: _____

Mothers Work Name & Address _____

Days of the Week _____ Hours _____

Mothers Work Phone _____ Cell Phone _____

Fathers Work Name & Address _____

Days of the Week _____ Hours _____

Fathers Work Phone _____ Cell Phone _____

Emergency Contact Name and Phone

1. _____

2. _____

3. _____

OVER.....

Please record days and times Summer Care will be needed on the attached summer schedule. The Program is available Monday through Friday from 7:00 a.m. to 6:00 p.m.

\$18.00 Registration Fee Paid _____ Date _____ Cash _____ or Check Number _____

| | | |
|---------------------|--------------------|-----|
| Summer Program Rate | Daily \$40/Day | YES |
| | Hourly \$4.80/hour | YES |

I agree to pay this rate for the duration of the Summer Program (6/5/17 to 8/18/17)

Parent Signature _____ Date _____

Please list and describe any medical conditions or allergies that the Summer Care Staff should be aware of.

If necessary the emergency cards on file in the Grace Lutheran School Office for the current academic year will be used for needed information. Parent signature below authorizes the use of this information as well as permission for the Summer Care Staff to call 911 for emergency medical needs.

Parent Signature _____ Date _____

Grace Ev. Lutheran Church and School
262-251 7140 Ext. 109
Summer Care Program
Child Pick-Up Authorization

The people listed below are authorized to pick up my child(ren):

Child(ren)'s name(s): _____

from the Grace Lutheran Church and School 2017 Summer Care Program.

| Name | Telephone Number |
|----------|------------------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |

PLEASE NOTE:

YOU AND YOUR DESIGNATED PICK UP PEOPLE WILL BE ASKED TO SIGN YOUR CHILD(REN) IN AND OUT OF THE SUMMER CARE PROGRAM. ANYONE COMING TO PICK UP YOUR CHILD(REN) WHO IS NOT ON THIS LIST WILL NOT BE ALLOWED TO LEAVE WITH YOUR CHILD(REN) UNLESS AN EXTENDED CARE WORKER HAS RECEIVED A WRITTEN NOTIFICATION IN PERSON FROM THE PARENT. AT TIME OF PICK-UP THIS PERSON WILL BE ASKED FOR AN APPROPRIATE FORM OF IDENTIFICATION. THIS IS TO ENSURE THE SAFETY OF YOUR CHILD(REN) – THERE WILL BE NO EXCEPTIONS TO THIS POLICY. PARENT SIGNATURE BELOW ACKNOWLEDGES ACCEPTANCE OF THIS POLICY.

Parents Signature _____ Date _____

**GRACE LUTHERAN CHURCH AND SCHOOL
SUMMER SIZZLERS
GENERAL FIELD TRIP PERMISSION FORM**

Grace Lutheran School Summer Sizzlers will be taking several field trips which will take them off the grounds of Grace Lutheran Church and School. These may include, but are not limited to, walking to Dairy Queen, the farmer's market, the park, swimming at North Middle, or other short walks in Menomonee Falls. In addition Summer Sizzlers will be traveling to other field trips requiring a bus journey. In order for your child(ren) to be able to participate we need you to sign and return the attached FIELD TRIP PERMISSION FORM.

PLEASE RETURN THIS PERMISSION FORM AS SOON AS POSSIBLE.

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**GRACE LUTHERAN CHURCH AND SCHOOL
EXTENDED CARE PROGRAM
GENERAL FIELD TRIP PERMISSION FORM**

NAME/GRADE: _____

I/We authorize the above named student to attend all Grace Lutheran Summer Care field trips during the period of 6/5/17 to 8/18/17 that will take him/her off the grounds of Grace Lutheran Church and School. I/We, the undersigned, understand that Grace Lutheran Church and School and all volunteer sponsors or supervisors assume no financial responsibility for the above named student. I/We agree to indemnify and hold harmless the Church Board of Directors, the Pastors, Church Staff, School Staff, Summer Care Staff and all approved volunteers of claims, damages, demands or causes of action resulting directly from the activities of the Grace Lutheran Summer Care Program. Further I/We authorize the following persons to secure medical treatment from a doctor or a hospital in the event the participating person(s) is/are injured at any time during this event.

PARENT/GUARDIAN SIGNATURE : _____

PARENT/GUARDIAN NAME (PRINT): _____

MEDICAL INSURANCE COMPANY: _____

POLICY HOLDER AND NO: _____

CHILDS PHYSICIAN AND CONTACT TEL. NO.: _____