

## PARENT AUTHORIZATION

Child(ren)'s Name(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the director or person in charge to take my child to:

Name of Licensed Physician	Complete Address	Phone
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Name of Hospital/Clinic	Complete Address	Phone
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I give consent for necessary emergency treatment when my child is in the care of this physician and/or hospital/clinic. I also understand that any expense incurred will be the parents'/guardian's responsibility.

Signature of Parent/Legal Guardian	Date
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Payment is due on the first school day of the month. A \$10 late fee will be automatically added to your account on the 15<sup>th</sup> of the month if payment has not yet been made. If payment has not been made as of the last day of the month, your child will not be allowed to attend class until your account is paid in full.

I have read and agree to the above statement.

Signature of Parent/Guardian	Date
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Indiana Avenue Preschool and Parents Day Out has my permission for the following:

- To use my child's photo for display or in printed materials
- To include my address and phone information in a directory

Signature of Parent/Guardian	Date
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Parents' E-mail address: \_\_\_\_\_