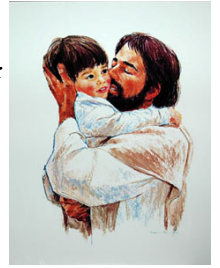

Zion Lutheran Child Care Center

N48 W18700 Lisbon Road
Menomonee Falls, WI 53051
262-781-6719



AUTHORIZATION FORM

CHILD'S FULL NAME _____ BIRTHDAY _____

ADDRESS _____ PHONE# _____

CITY _____ ZIP _____

Release: In case of emergency, accident, or serious illness to the student named on this form in which medical treatment is required, I (parent/guardian) request the center contact me. If the center is unable to reach me, my signature below authorizes the center to exercise their own judgment in contacting the physician indicated and to follow his/her instructions. If this physician is unavailable, the center may make whatever arrangements are necessary or transport the student to a hospital emergency room.

I have had an opportunity to review the policies of this child care center, and fully understand them.

I do give permission for my child to participate in field trips and other activities during operating hours.

Parent/Guardian signature

Date signed
