Child Care Form

Ages Infant - 12 yrs

Parent Last Name:_____ First Name:_____ MI:_____

Child Name:_____ DOB:_____ Age:_____ M / F

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Child Name:_____ DOB:_____ Age:_____ M / F

Mailing Address:_____ City:_____ State:_____ Zip:_____

Emergency Contact Name:_____ Relationship:_____

Emergency Phone Number:_____ _____ _____

HEALTH HISTORY FORM

Does your child have any limitations, health problems, or food allergies we should be aware of? YES / NO

_____

_____

_____

CHILD CARE AGREEMENT

I understand that by participating in child care that my child has the right to enjoy all activities associated with the care and will be subject to all the rules of the SCCH Fitness Center. I understand that a violation of these rules may result in termination of their enrollment.

All class fees are non-refundable and non-transferable.

I agree to indemnify and hold harmless Sullivan County Community Hospital Fitness Center and their agents and employees from any liability for any claim, demands, costs, or judgements it or them arising from my participating in child care. I relinquish all liability towards the SCCH Fitness Center, volunteers and all entities involved for any injuries or damages that may occur while in child care.

_____ _____

Member Signature Date

_____ _____

Fitness Center Staff Member Signature Date