

The Secret Garden

Summer Program

Nature, Play, Relationship based programs for ages 2-6

Child's full name:

Date of birth:

Address:

PHONE: 541-482-5543

paulailynam@gmail.com
davenourie@gmail.com

Summer Program Mornings (AM) 8:30-12:30 M-F \$165 per week

Additional Afternoon Hours (PM) 12:30-2:30 T.W.TH \$16 each

Date: ___/___/___

There is a \$25 no refundable deposit per week to reserve your placement.

We will meet on Monday/Friday at Emigrant Lake and Tuesday/Wednesday/Thursday at 782 Park Street.

DATES		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Week 1 JULY 8-12	AM PM					
Week 2 JULY 15-19	AM PM					
Week 3 JUL 22-26	AM PM					
Week 4 JUL 29-2	AM PM					

Parent/Guardian:

Phone:

Address:

Work Place & Address:

Phone(work):

E-mail:

Parent/Guardian:
Phone:
Address:

Work Place & Address:
Phone(work):
E-mail:

Child resides with: parent 1 parent 2 both parents guardian: (name)

EMERGENCY CONTACTS:

Name: _____ **Relation:** _____ **Phone:** _____

Name: _____ **Relation:** _____ **Phone:** _____

Emergency Doctor: _____ **Phone:** _____

Insurance Company: _____ **Number:** _____

Emergency Dentist: _____ **Phone:** _____

Insurance Company: _____ **Number:** _____

Preferred Hospital: _____ **Date of last DPT shot:** _____

Food/Medication allergies: _____

Current medications: _____

Special health conditions: _____

Please read the following, and initial indicating you have; "read, understood and agree"

___ I hereby grant permission for my child to use all of the play equipment and to participate in all of the activities of this early childhood program.

___ I hereby grant permission for my child to leave the facility under proper supervision for neighborhood walks.

___ I hereby grant permission for my child to be included in evaluations and pictures connected with the program.

___I hereby grant permission for Paula Lynam or The Secret Garden staff to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include but are not limited to the following:

1. Attempt to contact a parent or guardian.
2. Attempt to contact the child's physician.
3. Attempt to contact a parent/guardian through any of the persons listed on the emergency information section of this form.
4. If we cannot contact you or your child's physician, we will do any or all of the following: a) call another physician or paramedics, b) have your child taken to an emergency hospital in the company of the provider or a staff member.
5. Any expenses under number 4 above will be borne by the child's family.

Parent/Guardian Signature:

Date:

LIABILITY WAIVER: In consideration of premises, services, and/or the equipment provided, I, for myself and any minor children for which I am the parent, legal guardian or otherwise responsible, any heirs, personal representatives or assigns, do hereby release Paula Lynam, Playful Concepts LLC, The Secret Garden Pre-school/Playschool & Kindergarten, employees and sub contractors contracted, from all liability and expressly waive any claim for damage arising from any cause whatsoever associated with activity at Playful Concepts LLC and assessments or classes, The Secret Garden Pre-school/Playschool & Kindergarten with the exception of that which is the result of gross negligence or wanton and willful misconduct.

I have read the foregoing release statement. I understand that by signing this document I may be waiving valuable legal prerogatives.

Parent/Guardian's

Name: _____ **Signature:** _____

Participant's

Name: _____ **Date:** _____

Provider's Name:

Signature: _____ **Date:** _____

