OUR LADY OF GRACE EXTENDED CARE PROGRAM
ANNOUNCES
THE APRIL 22TH RELEASE DAY PROGRAMMING

Date Due By: April 1, 2019

Dear Parent's,

We are happy to announce that we will be offering
Full Day Care (7:00 a.m. - 6:00 p.m.)

Monday, April 22 , 2019 Doing Good Together
Come and work on some hands on activities to help in our community and
Air Maxx adventure in the afternoon

Please return this sheet along with the parental release form and payment.
The cost of the program is $ 52.00 per child per day.
Names:

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**** You will be billed through Smart Tuition

**** Remember to send a packed Lunch for your child!

If you should have any questions, please let me know.

Sharon Hierlmaier
Extended Care Director
Our Lady of Grace 612-240-351

Parental/ Guardian Consent Form and Indemnity Agreement

Participant's Name:____

Birth Date: ______________________________ Sex ______________

Parent/ Guardian's Name: ____

Home Address: ____

Cell Phone: ______________________ Business Phone: __________________

Please Initial:

_____Monday, April 22, 2019 Doing Good Together at Our Lady of Grace and Air Maxx

Individual(s) in Charge:
Mrs. Sharon Hierlmaier/ Staff
Estimated time of departure and return: 1:45- 4:30
Mode of transportation to and from event: School Bus
Student cost: $ 52.00 per student per day

I, __________________________, grant permission for __________________________
Parent or guardian's name Child's Name
to participate in the above named activity and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify the parish/ school and the Archdiocese of St. Paul/ Minneapolis from any claims or law suits brought against the parish/ school/ Archdiocese of St. Paul/ Minneapolis by myself, my child or others, that arise out of any behavior by my child at the event/ activity described above. I also agree to pay reasonable attorney's fees or expense incurred by the parish/ school and Archdiocese in defense of such a claim/ law suit.

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my child to a hospital for emergency medical treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

________________________________ ________________________________
(Name) (Phone Number)

Medication my child is taking at present: ______________________________________

Family Health Plan Carrier Number: ____

Family Doctor: ___________________________ Phone Number ______________________

As parent or guardian, I agree to all of the above stated considerations and conditions.

___________________________________ _________________
(Signature) (Date)