

**SATURDAY NIGHT DINNER CHILD CARE REGISTRATION  
FOR CHILDREN AGES 5-12  
Saturday, May 31, 2008**

**DEADLINE: May 16, 2008.** Please fill out and return to the Office of Alumni Relations by mail (Box 417, Gettysburg College, Gettysburg, PA 17325) or fax (717-337-8560).

Please fill out the following information for each child:

Name	Age on May 31, 2008	Sex

**DINNER & A MOVIE, 6 - 9 P.M. (Includes staffing, dinner, games, reading, and a movie.)**

	Cost	#	TOTAL
Each child	\$15		\$

<b>Grand Total</b>	<b>\$</b>
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Enclosed is my check for \$\_\_\_\_\_ made payable to "Gettysburg College".

Please charge \$\_\_\_\_\_ to (circle one):      Visa                      MasterCard                      Discover

Account #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_ Cardholder's signature: \_\_\_\_\_

Parent(s) Name(s): \_\_\_\_\_ Class Year(s): \_\_\_\_\_

Address: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ Fax: \_\_\_\_\_

Email (H): \_\_\_\_\_ (W): \_\_\_\_\_

**WAIVER OF CLAIMS & RELEASE FROM LIABILITY**

Please read this statement carefully and sign at the bottom.

I, the undersigned, declare that:

- I agree that I and my daughter(s)/son(s)/ward(s) will abide by the rules and regulations imposed by Gettysburg College and its employees or agents.
- I understand and appreciate that there are a number of inherent risks involved in the activity that I, and my daughter(s)/son(s)/ward(s) have chosen to participate in which are beyond the control of the College, its employees, or its agents, and I agree to assume such risks personally and to waive any claims that I, and my daughter(s)/son(s)/ward(s) may have against the College, its employees, or its agents, for personal injury and property damage.
- I understand that during every program, attention will be given to the health and comfort of the participants, but the College, its employees, or its agents shall not be responsible for any injuries sustained.

I, the undersigned, hereby authorize the employees and/or agents of Gettysburg College, at their sole discretion, to secure such medical advice and/or services as may be deemed necessary for my health and safety or that of my daughter(s)/son(s)/ward(s), and I agree to accept full financial responsibility for such advice or services. Furthermore, in consideration of my participation in this program sponsored by Gettysburg College, I do hereby release and forever hold harmless its employees, agents, and any other persons acting on its behalf from any and all claims, demands, rights and causes of action of whatsoever kind and nature for damage to property and for any and all bodily or personal injuries which may be sustained as a consequence of my participation or presence.

This release is given by me freely and binds not only me, but also my heirs, assigns and legal representatives.

I/We, the undersigned, are the parents or legal guardians of the child participating in a program sponsored by Gettysburg College. I/we have read the provisions of this document and consent/release Gettysburg College from any/all liability.

Name of parent/guardian of child (please print): \_\_\_\_\_

Signature of parent/guardian of child: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** Please fill out the information on the next page of this form completely. →

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**Please print in ink. For this side, please use one form per child. Make additional copies if needed or contact the Office of Alumni Relations (717-337-6518, alumni@gettysburg.edu).**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_

**EMERGENCY NOTIFICATION**

In the event of an emergency during the child's participation in the Saturday Childcare Program held on the Gettysburg College Campus, please notify the following:

Adult's Name		
Relationship		
Address while at Reunion Weekend (if known)	<input type="checkbox"/> On Campus:	<input type="checkbox"/> Off-Campus:
Cell Phone and/or Pager #'s		

**MEDICAL HISTORY/INFORMATION**

The child is allergic to (medicines, environment, food, etc.): \_\_\_\_\_  
\_\_\_\_\_

The child requires the following medication(s) on a regular basis:

Name of Medication	Dose	How Often/Times

Please list any special circumstances concerning the child we should be aware of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Personal Physician: \_\_\_\_\_

Physician's Phone #: \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

	Insurer #1	Insurer #2
Name of Insurance Co.		
Address of Insurance		
Phone Number of Insurance		
Subscriber's Name		
Relationship To Participant		
Policy #		
Policy Period		