



**WHEN:** First Friday of each month  
**TIME:** 6:30 p.m. – 10:00 p.m.  
**WHERE:** Early Childhood Center  
**PRICE:** \$10 per child / per day  
 (Maximum of \$20 per family / per day)

**QUALIFIED CHILDCARE STAFF:**  
 Background checked  
 CPR & First-Aid Certified

**BABYSITTING PROGRAM FOR INFANTS THROUGH AGE 12**

September 2008 through June 2009

**PLEASE NOTE:** Children are separated into playrooms by age. Activities include: playground, games, and movies. All children must have eaten dinner prior to attending *Parents' Night Out*. In addition, they must bring snacks, drinks, diaper bags (if applicable), and a change of clothes.

**- September 2008 through June 2009 -**

**Registration form due date**

08/31/2008  
 09/28/2008  
 11/02/2008  
 11/30/2008  
 12/28/2008  
 02/01/2009  
 03/01/2009  
 04/26/2009  
 05/31/2009

**Parents' Night Out date**

09/05/2008  
 10/03/2008  
 11/07/2008  
 12/05/2008  
 01/02/2009  
 02/06/2009  
 03/06/2009  
 05/01/2009  
 06/04/2009

Registration forms and payments ***must be received*** by the preceding Sunday.  
 Save yourself the trouble and register in August for all ten dates.

**Make checks payable to: Coral Gables Congregational Church.**

For more information, please contact  
 Megan Korallis, Director of Christian Education  
 305-448-7421, ext. 19 • [MeganK@ucc-cgcc.org](mailto:MeganK@ucc-cgcc.org)

Coral Gables Congregational Church  
 United Church of Christ  
 3010 De Soto Boulevard  
 Coral Gables, Florida 33134

[www.coralgablescongregational.org](http://www.coralgablescongregational.org)



**- Release Form -**

**First child**

I, \_\_\_\_\_, hereby give permission for my child, \_\_\_\_\_, male/female (please circle one), age \_\_\_\_\_, date of birth \_\_\_\_\_, in grade \_\_\_\_\_, to participate in *Parents' Night Out*–Babysitting Program at Coral Gables Congregational Church, on (please check the dates below), **from 6:30 p.m. to 10:00 p.m.**, at a rate of \$10 per child/per day or maximum of \$20.00 per family/per day.\*

- |                                     |                                     |                                     |
|-------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> 09/05/2008 | <input type="checkbox"/> 12/05/2008 | <input type="checkbox"/> 03/06/2009 |
| <input type="checkbox"/> 10/03/2008 | <input type="checkbox"/> 01/02/2009 | <input type="checkbox"/> 05/01/2009 |
| <input type="checkbox"/> 11/07/2008 | <input type="checkbox"/> 02/06/2009 | <input type="checkbox"/> 06/05/2009 |

**Second child** (complete if applicable)

I, \_\_\_\_\_, hereby give permission for my child, \_\_\_\_\_, male/female (please circle one), age \_\_\_\_\_, date of birth \_\_\_\_\_, in grade \_\_\_\_\_, to participate in *Parents' Night Out*–Babysitting Program at Coral Gables Congregational Church, on (please check the dates below), **from 6:30 p.m. to 10:00 p.m.**, at a rate of \$10 per child/per day or maximum of \$20.00 per family/per day.\*

- |                                     |                                     |                                     |
|-------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> 09/05/2008 | <input type="checkbox"/> 12/05/2008 | <input type="checkbox"/> 03/06/2009 |
| <input type="checkbox"/> 10/03/2008 | <input type="checkbox"/> 01/02/2009 | <input type="checkbox"/> 05/01/2009 |
| <input type="checkbox"/> 11/07/2008 | <input type="checkbox"/> 02/06/2009 | <input type="checkbox"/> 06/05/2009 |

**- Parent or Guardian Contact Information -**

Parent or Guardian's name: \_\_\_\_\_  
Church Membership: CGCC \_\_\_\_\_ Other: \_\_\_\_\_ None: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
If unable to reach, please contact: \_\_\_\_\_ at \_\_\_\_\_  
Person(s) authorized to pick-up this child: \_\_\_\_\_

**- Emergency Medical Information -**

Child's physician's name: \_\_\_\_\_  
Child's medical concerns of which we should be aware: \_\_\_\_\_  
\_\_\_\_\_  
Any known allergies: \_\_\_\_\_  
*I authorize medical treatment for my child in case of an accident or illness, if the parent or guardian cannot be located or an emergency situation should arise.*  
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*CANCELLATION POLICY: There are no refunds given for this program.**