

# The CHASTAIN School

A Child Development Center & Preschool

## **Parent's Night Out Enrollment & Waiver**

In the event of an emergency involving my child, and The Chastain School cannot reach me at the numbers below, I hereby authorize any needed emergency medical care and agree to be fully responsible for all medical expenses incurred during the treatment of my child.

In the event of an emergency, the School transports children to:

Children's Healthcare of Atlanta at Scottish Rite Children's Hospital  
1001 Johnson's Ferry Rd.  
Atlanta, GA 30342  
(404) 256-5252

I have read and agree to the terms stated above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **Contact Information**

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Allergies: \_\_\_\_\_

Daily Medication: \_\_\_\_\_

Special Instructions or Needs:

### **Parent Insurance Info:**

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Claims Phone Number: \_\_\_\_\_