

## Parental Agreement

I agree that the Directors may authorize the physician of his/ her choice to provide the emergency care in the event that neither the family physician nor I can be contacted.

\_\_\_\_\_ Date \_\_\_\_\_  
Signature

I understand that as a family of the Chapel Hill Day Care Center I will commit to 3 hours of Parent Participation annually.

\_\_\_\_\_ Date \_\_\_\_\_  
signature

I give permission for my child to be given eye and dental screenings.

\_\_\_\_\_ Date \_\_\_\_\_  
signature

I give permission for photographs and video to be taken of my child while attending Chapel Hill Day Care Center or involved in center activities.

\_\_\_\_\_ Date \_\_\_\_\_  
signature