Solon Early Childhood PTA – Babysitting Co-op Authorization Form

August 2014 – August 2015

PURPOSE: The purpose of the SECPTA Babysitting Co-op is to provide members a babysitting option where no money is exchanged.

Member Name:	Spouse's Name:	
Address:	Home Phone:	
	Work/Cell Phone:	
Member Email Address:		
	rth Date Health Concerns	
Relative to contact in emergency:	Phone:	
Neighbor to contact in emergency:	Phone:	
Physician:	Phone	
Address:		
Preferred Hospital	Insurance	
Disclosures:		
Do you or your spouse smoke? Yes No		
o you have any pets? Yes No If yes, describe:		
Do you have any firearms in your home? Yes	No If so, are they securely locked? Yes No	

We authorize whatever treatment is necessary to treat our child(ren) in case of emergency or accident when neither of us can be located. Such treatment is to be performed by the physician named above, by a physician of his/her choice, or by an emergency room physician.

The Babysitting Co-op adheres to the communicable disease policy adopted by the general membership of SECPTA. It reads as follows:

Children and/or parents should not attend any SECPTA events if they exhibit any of the following symptoms; Diarrhea more than once within 24 hours of the event; severe coughing; difficult or rapid breathing; yellowish skin or eyes; redness of the eye or eyelid including discharge, eye pain, matted eyelashes, burning or itching; temperature of 100 degrees Fahrenheit or higher; infected skin patches; unusual spots or rashes; unusually dark urine and/or gray or white stools; stiff neck with an elevated temperature; sore throat or difficulty swallowing; vomiting within 24 hours of the event; or evidence of untreated lice, scabies, or other parasitic infestations.

I hereby acknowledge that I have read and understand the by-laws that govern the Babysitting Co-op and agree to fully abide by their rules and regulations.

Signed:	Mother	Date :
	Father	Date :