Welcome to the Children's Waiting Room!

Date	Name of Parent / Guardian		Relationship to Child
Address		City	Zip
Cell Phone or Pager	Name of Alternate Emergency Contact		Phone Number
Time In / Initials	Time Out / Initials	Court Department	Ethnicity (optional)

RULES TO MAKE IT FUN (AND SAFE) FOR EVERYONE….

(initial each)

_____ If your child has any communicable illness, he/she may not use the CWR. No medicines are allowed in the CWR.

_____ The person registering the child and receiving the stamp **MUST** be the same person, with stamp still visible, who picks up the child.

_____ You **MUST** remain in the courthouse while your child is in the CWR and **MUST pick your child up by 12:00 pm and by 5:00 pm (Mon - Thur) and by 11:30 am on Friday.**

_____ If your child's behavior is inappropriate or jeopardizes the health or well-being of any child or staff member in the program, we will contact you to pick up your child immediately.

_____ We will attempt to contact you if there is an emergency requiring medical attention for your child. Your signature below authorizes the CWR staff to call for emergency medical care for your child. **Any costs for emergency treatment and/or transportation of your child will be solely your responsibility.**

_____ The CWR has a video surveillance system in operation during all program operating hours.

Child 1

Last Name (if different)	First Name	Age	Sex M / F
Allergies? Y / N	If Yes, to What?	Reaction	
Special Needs/Medical Conditions		Primary Language	
Infant Feeding Plan		Staff Use: Stamp Issued	

(over for more children)

I have read, understand, and agree to abide by the rules of the Children's Waiting Room. I understand that failure to abide by these rules could result in the loss of the privilege of using the CWR. I agree to hold harmless the Children's Waiting Room, KidCentric, the Superior Court of California, County of Sonoma, or any of its officers, agents or employees, from and against any claims, losses, liabilities or damages arising or resulting from our use of the Children's Waiting Room.

_____ _____

SIGNATURE **DATE**

Child 2

Last Name (if different)	First Name	Age	Sex M / F
Allergies? Y / N	If Yes, to What?	Reaction	
Special Needs/Medical Conditions		Primary Language	
Infant Feeding Plan		Staff Use: Stamp Issued	

Child 3

Last Name (if different)	First Name	Age	Sex M / F
Allergies? Y / N	If Yes, to What?	Reaction	
Special Needs/Medical Conditions		Primary Language	
Infant Feeding Plan		Staff Use: Stamp Issued	

Child 4

Last Name (if different)	First Name	Age	Sex M / F
Allergies? Y / N	If Yes, to What?	Reaction	
Special Needs/Medical Conditions		Primary Language	
Infant Feeding Plan		Staff Use: Stamp Issued	

STAFF USE ONLY

Parent/Guardian's Photo/ID #
Photo and Number confirmed at Check-in (initials)
Photo and Number confirmed at Check-out (initials)