Bozeman Deaconess
HOSPITAL

1600 Ellis Unit 1A · Bozeman, MT 59715 · (P) 406-587-7786 · 800-962-0418 · (F) 406-587-1682

2012 Super Sitter Registration Form

Please complete this form and return to Child Care Connections with payment of $35**.** You should receive a **letter the date you are registered for within 10 business days** of submitting your registration. If you do not receive a letter contact Shardai at 587-7786. Please feel free to call if you have any questions or need special arrangements.

Feel free to copy and re-use this form as needed.

Student Name: ________________________________Date of Birth___________________________

Parent Name: ______________________Mailing Address___________________________________

City__________________ State________ Zip_____ Best Contact Number____________________

Allergies/Accommodations Needed____

I would like to receive my confirmation letter via:
Postal mail_______ Email________ (Please provide your email address)_____________________

Please indicate your first, second and third choices. The first 12 students to register AND pay will be guaranteed a spot in their class of choice.

Each class is held 9am-3pm.

_____ January, 21 (Saturday) **_____February, 25 (Saturday)**

_____May, 12 (Saturday) **_____June, 12 (Tuesday)**

_____July, 23 (Monday) **_____August, 16 (Thursday)**

_____September, 22 (Saturday) **_____October, 13 (Saturday)**

_____December, 1 (Saturday)

We look forward to seeing you at our class! Due to the high demand for this class and the large volume of students turned away, we cannot refund or reschedule your child(ren) without a **24 hour advance notice of cancellation.**

For Child Care Connections Staff Use Only:

Date Received: __________ Cash / Check # _______________ Amount $__________