

**Children's Harbor Montessori School - Summer Studio 2018**

**Emergency/Medical Information and Transportation Form**

(It is very important to complete all information, and to notify your child's teacher and the office of any changes).

Child's name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ **Blood Type** \_\_\_\_\_

Child lives with \_\_\_\_\_ Language spoken in home \_\_\_\_\_

**Parent's Name** \_\_\_\_\_ **Parent's Name** \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Work \_\_\_\_\_ Work \_\_\_\_\_

Cell phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

e-mail \_\_\_\_\_ e-mail \_\_\_\_\_

**PERSONS AUTHORIZED TO PICK UP YOUR CHILD FROM SCHOOL:**

1. \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

2. \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

3. \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

(Please inform above listed that you have given the school their contact information)

**EMERGENCY CONTACTS, IF WE ARE UNABLE TO REACH YOU:**

1. \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_

3. \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_

(Please gain consent prior to listing above persons' contact information)

**(Please complete all information on Page 2)**

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**IF WE ARE UNABLE TO REACH YOU OR ANYONE ON YOUR CONTACT LIST, HOW WOULD YOU LIKE US TO TREAT YOUR CHILD?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PEDIATRICIAN:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE CARRIER** \_\_\_\_\_ I.D. # \_\_\_\_\_

**IS CHILD ALLERGIC TO ANY:** Medications \_\_\_\_\_ *(Specify)* \_\_\_\_\_

\_\_\_\_\_

Foods \_\_\_\_\_ *(Specify)* \_\_\_\_\_

\_\_\_\_\_

Insect bites \_\_\_\_\_ *(Specify)* \_\_\_\_\_

\_\_\_\_\_

**IS CHILD CURRENTLY TAKING ANY MEDICATIONS? *(Specify)***

\_\_\_\_\_

**SPECIAL HEALTH CONDITIONS: *( long term or chronic)***

1. \_\_\_\_\_

Medications or treatments \_\_\_\_\_

**SIGNIFICANT FAMILY HISTORY: *(Check any that apply to maternal or paternal sides)***

\_\_\_\_\_ Diabetes      \_\_\_\_\_ Convulsive Disorder      \_\_\_\_\_ Heart Disease

\_\_\_\_\_ Hypertension      \_\_\_\_\_ Tuberculosis      \_\_\_\_\_ Sickle Cell      \_\_\_\_\_ Vision

\_\_\_\_\_ Hearing      \_\_\_\_\_ Other *(Specify)* \_\_\_\_\_

**CONSENT FOR EMERGENCY MEDICAL TREATMENT**

I do hereby give authority to Children's Harbor Montessori School staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

Signed: \_\_\_\_\_ Date \_\_\_\_\_