Children's Harbor Montessori School

Emergency/Medical Information and Transportation Form

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

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 _____

4. _____ 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 PAGE 2- Reverse Side)**

Please complete information on reverse of this form and sign.

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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 _____