Country Montessori School

EMERGENCY INFORMATION

NOTE: PLEASE INFORM OFFICE OF ANY CHANGES IMMEDIATELY

Child's name: ________________________________ Age ____ Date of Birth _______________ Sex _____

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Home address: ____

City _________________________ Zip ____________ Phone _______________ Cellular _______________

E-mail Address:____

Child lives with: Father & Mother _____ Mother _____ Father _____ Other _____

Person(s) legally responsible for
Child: ____

Person(s) to be called in case of accident or illness who are authorized to pick up child:

Mother/Guardian

Name _______________________________ Business Phone & Hours ________________________________

Firm Name _______________________________________ Cell/Pager ________________________________

Occupation ____________________ Address _________________________________ City _______________

Father/Guardian

Name _______________________________ Business Phone & Hours ________________________________

Firm Name ______________________________________ Cell/Pager _________________________________

Occupation ____________________ Address ________________________________ City ________________

Alternate persons to be called if parents or guardians cannot be reached (local residents only, no one out of the county) also authorized to pick up child:

Name ________________________________ Relationship ____________________ Phone _____________

Address ____ City ______________________

Country Montessori School

Name ________________________________ Relationship ____________________ Phone _____________

Address ____ City ______________________

Name ________________________________ Relationship ____________________ Phone _____________

Address ____ City ______________________

Doctors to be called in an emergency:

Physicians

Name _____________________________

Address ___________________________

City ______________________________

Telephone _________________________

Child's regular doctor? ________________

Dentist

Name _____________________________

Address ___________________________

City ______________________________

Telephone _________________________

I hereby give my consent to Country Montessori School to administer First Aid, to authorize a medical doctor to examine or treat my child/ren, __________________________, to authorize necessary emergency treatment at a nearby medical facility, and/or to order ambulance transportation for my child while he/she is at Country Montessori School, and/or school related off-campus activities. I agree to accept the financial responsibilities for any and all costs incurred in the treatment of any illness, accident, or injury of the above named minor.

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Parent Name Signature Phone Date

07-08