Garden Montessori School ~ Emergency Contact & Medical Waiver

Child's Full Legal Name: _____ Birth Date: _____

Address: _____

_____

Please rank phone numbers (1,2,3) in the order you wish to be called.

Father's Name: _____

__ Home: _____

__ Cell: _____

__ Work: _____

Email Address: _____

Place of Employment: _____

Mother's Name: _____

__ Home: _____

__ Cell: _____

__ Work: _____

Email Address: _____

Place of Employment: _____

Please provide alternative contacts in the event that parents cannot be reached in an emergency.

Contact's Name: _____

Relationship: _____

__ Home: _____

__ Cell: _____

__ Work: _____

Contact's Name: _____

Relationship: _____

__ Home: _____

__ Cell: _____

__ Work: _____

Contact's Name: _____

Relationship: _____

__ Home: _____

__ Cell: _____

__ Work: _____

Contact's Name: _____

Relationship: _____

__ Home: _____

__ Cell: _____

__ Work: _____

The following persons are authorized to pick-up my/our child from school:

Contact's Name: _____

Relationship: _____

__ Home: _____

__ Cell: _____

__ Work: _____

Contact's Name: _____

Relationship: _____

__ Home: _____

__ Cell: _____

__ Work: _____

Contact's Name: _____

Relationship: _____

__ Home: _____

__ Cell: _____

__ Work: _____

Contact's Name: _____

Relationship: _____

__ Home: _____

__ Cell: _____

__ Work: _____

Health Record

May answer YES or NO – Give dates if applicable

Heart Disease: _____

Diabetes: _____

Epilepsy: _____

Seizures or Convulsions: _____

Ear Problems / Tubes: _____

Vision problems: _____

Does your child wear glasses? ☐ Yes ☐ No

Asthma ☐ Yes ☐ No Under Doctor's Care? ☐ Yes ☐ No

*Allergies: (Please be specific) Under doctor's care? ☐ Yes ☐ No

Food: _____

Bee Stings: _____

Other: _____

Benadryl? ☐ Yes ☐ No Epi Pen? ☐ Yes ☐ No

Treatment: _____

** If your child has an allergy, please attach a piece of paper describing the allergy – specific allergen(s), reaction, treatment, etc.*

Other serious illness or handicap: _____

Operations (type and date): _____

Are there any restrictions to your child's physical activity? _____

Is your child presently taking prescribed medication? ☐ Yes ☐ No If yes, please list: _____

Please Note: Garden Montessori staff are not permitted to administer any medication, except in case of allergic reaction or asthma.

Is your child a vegetarian? ☐ Yes ☐ No If yes, please specify if your child eats eggs or consumes milk products: _____

Does your child have any other dietary restrictions? _____

Does your child have any fears of which we should be aware? _____

Does your child need any assistance of which we should be aware? _____

In Case of Emergency

Medical Insurance Company: _____

Policy Number: _____

Medical Waiver and Authorization

I certify that my child is in good health and can participate in all normal activities of the group. Listed above are any health concerns regarding my child (diabetes, history of epilepsy, allergies, etc.) and any medication that might be needed. I hereby give permission to Garden Montessori to seek emergency medical treatment for the minor / child _____. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to Garden Montessori staff to arrange necessary related transportation for the minor child named above.

In case of medical emergency, every reasonable effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission for the medical personnel selected by Garden Montessori staff to secure and administer medical treatment including to hospitalize, order and administer medications and anesthesia, perform x-rays, special procedures, or surgery, if deemed medically necessary for the minor child named above, for which charges I shall be responsible and agree to pay.

Parent / Guardian Signature: _____ Date: _____