When You Want to Give Your Child The Best Educational Start

Sikora Montessori

Medical/Emergency and Illness Information

Child's Name: _____

Home Address: _____ Date of Birth: _____

_____ Gender: ☐ Male ☐ Female

Parent Information

Mother (or Primary Custodial Parent)

Name: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Email: _____ Work Phone: _____

Place of Employment: _____

Address of Employer: _____

_____

Father (or Other Primary Custodial Parent)

Name: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Email: _____ Work Phone: _____

Place of Employment: _____

Address of Employer: _____

_____

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Persons to Contact in an Emergency Other Than Parents

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

_____ Relationship: _____

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

_____ Relationship: _____

Physician/Dentist/Hospital Information

Doctor: _____ Phone: _____

Address: _____

Dentist: _____ Phone: _____

Address: _____

Preferred Hospital: _____ Phone: _____

Address: _____

Name of Insurance Provider: _____

Address: _____

Phone: _____ Policy Number: _____

Health Information and Special Instructions
(Special Dietary or Other Medical Needs, Etc.)

Are there any unusual health conditions? (Please list)

_____

_____

_____

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Health Information Cont'd

☐ Asthma	☐ Bee Sting Allergy	☐ Internal Irregularities
☐ Arthritis	☐ Deafness	☐ Convulsive Disorders
☐ Diabetes	☐ Heart	☐ Sight Impairment
☐ Dental Appliances	☐ Kidney/Bladder	☐ Wears Glasses
☐ Fractures	☐ Medications: _____	

Please list any physical or non-physical disability or any other condition that the school should know about:

_____

_____

_____

Emergency Medical Treatment and Transportation Release

To Grant Consent

In the event that reasonable attempts to contact all persons listed have failed, I hereby give my consent to the administration for treatment deemed necessary by the doctor or dentist referred to on this form. In the event the designated preferred practitioner is not available, treatment may be provided by another licensed physician or dentist. Permission is also given for the transfer to the hospital listed on this form or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists are obtained and concur in the necessity for surgery prior to the performance of such surgery. Facts concerning medical history, including allergies, medications being taken, and to physical impairments to which a physician or dentist should be alerted are listed on this form.

_____ Date ___/___/___
Signature of Parent

_____ Date ___/___/___
Signature of Parent

Refusal to Consent

I do not give my consent for emergency medical treatment. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action OR to do the following: _____

_____ Date ___/___/___
Signature of Parent

_____ Date ___/___/___
Signature of Parent

Revised July 15, 2015