THE MONTESSORI CHILDREN'S SCHOOL
EMERGENCY MEDICAL CARE INFORMATION & AUTHORIZATION

Student Name: ________________________________ **Program:** ________________DOB: ______________

Emergency Medical Care Information

Insurance Provider: _______________________________ Policy/Social Security #: _______________________

Physician's Name: ____ Phone #: ________________________

Address: ____

Dentist's Name: ____ Phone #: ________________________

Address: ____

Hospital Preference: ____

Health Care Needs

For any child with health care needs such as allergies, chronic illnesses such as asthma, diabetes and epilepsy that require specialized health services, a medical action plan shall be attached to this form. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached? Yes __ No __

List any allergies and the symptoms and type of response required for allergic reactions

____

List any health care needs or concerns, symptoms or and type of response for these health care needs or concerns

____

List any particular fears or unique behavior characteristics the child has

____

List any types of medication taken for health care needs____

Share any other information that has a direct bearing on assuring safe medical treatment for your child

____

Emergency Medical Care Authorization

In the event of a medical emergency or illness, the School will contact the parents or guardians first.
If neither father nor mother (or guardian) can be contacted, I authorize the following individuals to respond:

Name ____ Relationship:__________________________________

Home Phone: _______________ Work Phone: _____________________Cell Phone:_______________________

Name ____ Relationship:__________________________________

Home Phone: _______________ Work Phone: _____________________Cell Phone:_______________________

Name ____ Relationship:__________________________________

Home Phone: _______________ Work Phone: _____________________Cell Phone:_______________________

I hereby authorize the staff and/or Head of School at the Montessori Children's School, Inc. to give consent for any and all necessary emergency medical treatment for my child, ______________________________, while my child is in the care and custody of the staff and/or Head of School at the Montessori Children's School.

_________________________________	_____________________________	___________________
Printed Name of Parent or Guardian	Signature of Parent or Guardian	Date
_________________________________	_____________________________	___________________
Printed Name of Parent or Guardian	Signature of Parent or Guardian	Date

I, as the Administrator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the school will be supervised by a responsible adult. I will not administer any drug or any medication without specific instruction from the physician or the child's parent, guardian, or full-time custodian.

Signature of Administrator ____Date ____________________

Revised 04/2017