2023-2024 CALIFORNIA MONTESSORI PROJECT
MEDICAL AND EMERGENCY INFORMATION AND CONSENT

Student Name:	**Date of Birth:**	**Sex:** M ☐ F ☐ Non Binary ☐	**For Office Use Only:** Grade: Class:
Name of parent/guardian student resides with during school week:			
Address:			
Primary Phone #: Circle Phone Type: Home/ Work/ Cell	**Other Phone #:** Circle Phone Type: Home/ Work/ Cell		

1st Contact Parent (and allowed to transport student)	2nd Contact Parent (and allowed to transport student)
Name:	**Name:**
Physical Address: **City/Zip:**	**Physical Address:** **City/Zip:**
Primary Phone #: Circle Phone Type: Home/ Work/ Cell	**Primary Phone #:** Circle Phone Type: Home/ Work/ Cell
Other Phone #: **Email:**	**Other Phone #:** **Email:**
Business Name:	**Business Name:**
Business Address:	**Business Address:**
Business Phone #:	**Business Phone #:**
Additional Person who may be called and who may transport student	**Additional Person who may be called and who may transport student**
Name: **Relationship:** **Address:** **City/Zip:**	**Name:** **Relationship:** **Address:** **City/Zip:**
Primary Phone #: Circle Phone Type: Home/ Work/ Cell	**Primary Phone #:** Circle Phone Type: Home/ Work/ Cell
Secondary Phone #: Circle Phone Type: Home/ Work/ Cell	**Secondary Phone #:** Circle Phone Type: Home/ Work/ Cell
Other Phone#: Circle Phone Type: Home/ Work/ Cell	**Other Phone #:** Circle Phone Type: Home/ Work/ Cell

Any Legal Special Custody Arrangements: Please note below and provide a copy of legal court order.

PLEASE COMPLETE INFORMATION ON REVERSE SIDE

HEALTH INFORMATION

Please list any known health problems:
Specify symptoms which occur:
List any medications being taken by your child:
Does your child take medications prior to arriving at school? Yes No **Name of Medication:**
List known allergies: **Requires Medication:** Yes No
Does your child wear: Glasses? Yes No **Contacts?** Yes No **Hearing Aid?** Yes No
Please circle if your child has any of the following: Asthma Diabetes Dizziness Fainting Heart Disease Heart Murmur Muscle, Bone, or Joint Injuries Epilepsy/Seizures
Does your child use an inhaler? Yes No
Does your child require Assistive Devices (wheel chair, etc.)? Yes No **What type?**

IN CASE OF ACCIDENT OR OTHER EMERGENCY, I HEREBY AUTHORIZE A REPRESENTATIVE OF THE SCHOOL AND/OR CLUB MONTESSORI TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.), OSTEOPATH (D.O.) OR DENTIST (D.D.S) OR HOSPITAL CARE, INCLUDING NECESSARY TRANSPORTATION OF MY CHILD. UNDER SUCH CIRCUMSTANCES, I FURTHER AUTHORIZE SUCH CARE AND TREATMENT TO BE PERFORMED BY ANY LICENSED PHYSICIAN OR SURGEON. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL-BEING OF THE CHILD NAMED ABOVE. The undersigned hereby agrees to bear all costs incurred as a result of the foregoing. This authorization will remain in effect until revoked by the undersigned.

Medical Insurance Carrier & Policy #: _____

Family Physician: _____ **If unavailable, alternative?** _____

Address: _____ Phone: _____

Family Dentist: _____ **If unavailable, alternative?** _____

Address: _____ Phone: _____

Hospital of choice when possible: _____

Parent/Guardian Signature: _____ **Date:** _____