

EMERGENCY MEDICAL CARE FORM

Child's Last Name _____ First _____ M.I. _____ Gender _____ Date of Birth _____
M / F _____

Home Address
No. _____ Street _____ Apt # _____ State _____ Zip _____ Home Phone # _____

Pediatrician _____ Office Address _____ Office Phone # _____

EMERGENCY CONTACT INFORMATION

Please provide parent contact information as well as two alternative contacts.

Mother's Name _____ Work # _____ Cell # _____

Mother's Email _____

Father's Name _____ Work # _____ Cell # _____

Father's Email _____

Alternate Contact #1 _____

Alternate Contact #2 _____

MEDICAL CONDITIONS

Please indicate any known allergies and other medical conditions

Condition	Age Identified	Prescribed Treatment (if any)
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL CARE RELEASE STATEMENT

I/We, _____, authorize Children First Montessori School to obtain emergency medical care for my/our child, _____, in the event of a medical emergency.

Parent Signature _____ Date _____