MONTESSORI ACADEMY at BELMONT GREENE EMERGENCY CARE INFORMATION

LAST	FIRST	MIDDLE	
PROGRAM/TEACHER	LANGUAGE AT HOME	DATE OF BIRTH	SEX: ☐M ☐F

STUDENT RESIDES WITH ☐Father ☐Mother ☐Both ☐Legal Guardian

FATHER/Guardian

FULL NAME	EMAIL ADDRESS
ADDRESS	

Home Phone #	Work phone #	Cell Phone #

MOTHER/Guardian

FULL NAME	EMAIL ADDRESS
ADDRESS	

Home Phone #	Work phone #	Cell phone #

****REQUIRED List 2 persons we should call in an emergency if the parent/guardian cannot be reached**

Name of Person	**Relationship**	**Telephone**
Address:		
Name of Person	**Relationship**	**Telephone**
Address:		

ADDITIONAL INFORMATION

Name of Student's Physician Address:	Physician's Phone number
Name of Insurance Company:	Policy/Group/Employee # and/or HMO (if applicable)

MEDICAL INFORMATION - Check any current health condition that may require attention during the school day.

- ☐ Allergies (be specific)
  - ☐ Foods_____
  - ☐ Medications _____
  - ☐ Bee sting/Insect _____
- ☐ Diabetes
  - ☐ Asthma
  - ☐ Hearing Problems (be specific)_____
    _____
- ☐ Hemophilia
- ☐ Physical Disability (be specific)
  _____
- ☐ Respiratory (be specific)
  _____
- ☐ Seizures
- ☐ Vision Problems (be specific)
  _____

List all medications and dosages your child receives on a continual basis:_____
_____

Action to be taken in an emergency: _____
_____

In the event my child is ill or needs medical care, I agree to pick up my child as soon as possible if requested by MAB. MAB has my permission, in an emergency when I (or my physician) cannot be contacted to take my child to the emergency room of the nearest hospital. The hospital and its medical staff have my authorization to provide treatment which a physician deems necessary for the well being of my child. If my child or any member of my immediate household has developed any reportable communicable disease as defined by the State Board of Health, I know am required to notify MAB immediately.

PARENT/GUARDIAN SIGNATURE: DATE: