

MONTESSORI ACADEMY at BELMONT GREENE EMERGENCY CARE INFORMATION

LAST	FIRST	MIDDLE	
PROGRAM/TEACHER	LANGUAGE AT HOME	DATE OF BIRTH	SEX: <input type="checkbox"/> M <input type="checkbox"/> F
STUDENT RESIDES WITH <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Both <input type="checkbox"/> 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	Physician's Phone number
Address:	
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.	
<input type="checkbox"/> Allergies (be specific) <input type="checkbox"/> Foods _____ <input type="checkbox"/> Medications _____ <input type="checkbox"/> Bee sting/Insect _____	<input type="checkbox"/> Hemophilia <input type="checkbox"/> Physical Disability (be specific) _____ <input type="checkbox"/> Respiratory (be specific) _____
<input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Hearing Problems (be specific) _____	<input type="checkbox"/> Seizures <input type="checkbox"/> Vision Problems (be specific) _____
List all medications and dosages your child receives on a continual basis: _____	
Action to be taken in an emergency: _____	
<p>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.</p>	
PARENT/GUARDIAN SIGNATURE:	DATE: