

2021-2022 CALIFORNIA MONTESSORI PROJECT CHARTER SCHOOL MEDICAL AND EMERGENCY INFORMATION AND CONSENT

Student Name:	Date of Birth:	Sex: M <input type="checkbox"/> F <input type="checkbox"/> Non Binary <input type="checkbox"/>	For Office Use Only: Grade: Class:
Name of parent/guardian student resides with during school week:			
Address:			
Primary Phone #:	<small>Circle Phone Type: Home/ Work/ Cell</small>	Other Phone #:	<small>Circle Phone Type: Home/ Work/ Cell</small>

1 st Contact Parent (and allowed to transport student)	2 nd Contact Parent (and allowed to transport student)
Name:	Name:
Physical Address:	Physical Address:
City/Zip:	City/Zip:
Primary Phone #:	Primary Phone #:
<small>Circle Phone Type: Home/ Work/ Cell</small>	<small>Circle Phone Type: Home/ Work/ Cell</small>
Other Phone #:	Other Phone #:
Email:	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:	Name:
Relationship:	Relationship:
Address:	Address:
City/Zip:	City/Zip:
Primary Phone #:	Primary Phone #:
<small>Circle Phone Type: Home/ Work/ Cell</small>	<small>Circle Phone Type: Home/ Work/ Cell</small>
Secondary Phone #:	Secondary Phone #:
<small>Circle Phone Type: Home/ Work/ Cell</small>	<small>Circle Phone Type: Home/ Work/ Cell</small>
Other Phone#:	Other Phone #:
<small>Circle Phone Type: Home/ Work/ Cell</small>	<small>Circle Phone Type: Home/ Work/ Cell</small>

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:** _____