MARIA MONTESSORI CHARTER ACADEMY STUDENT EMERGENCY CARD

Student's Last Name	First Name	Birth Date	PK Grade	Gender	Children's House Classroom – Office Use Only
Mailing Address (Street, City, Zip)				( ) Best Contact Phone #	
Physical Address (if different)		E-Mail Address			

Name – Mother / Step Mother / Guardian	Home	Work	Cell/Pager
Name – Father / Step Father / Guardian	Home	Work	Cell/Pager

Parent(s) or guardian(s) child lives with _____

If parents are separated or divorced, to whom has physical custody been granted? _____

If my child is ill, has an emergency, or is suspended and I cannot be reached, please call and release my child to (must be over 18 years old and have ID):

Name – Emergency Contact	Home	Work	Cell/Pager
Name – Emergency Contact	Home	Work	Cell/Pager
Name – Emergency Contact	Home	Work	Cell/Pager

Physician's Name	Phone Number	Insurance Company	Insurance ID#

[ ] 1. In the event of an emergency, when a parent or guardian is unavailable, I authorize school personnel to make arrangements for my child to receive medical or hospital care, including necessary transportation, in accordance with their best judgment. I authorize the physician named above to undertake such care and treatment as is considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician or surgeon. I agree to pay all costs incurred as a result of the foregoing.

[ ] 2. I do not choose the above statement and desire the following action in the event of an emergency and I cannot be reached.

_____

PLEASE CHECK THE FOLLOWING ITEMS IF THEY PERTAIN TO YOUR CHILD

There are no known health problems [ ]

EYES

Wears Glasses [ ]To be worn at all times [ ]
Wears Contacts [ ] To be worn at all times [ ]
Comments:_____
_____

MEDICATION

Currently taking prescribed medication [ ]
Prescribing physician_____
Medication _____
For _____
Medication needs to be taken at school [ ]
If any medication (including over-the-counter) needs to be taken at school, the medication must be kept in the office and a medication form must be filled out and kept in the office.

EARS

Has a hearing problem [ ]
Has tubes in ear(s) [ ]
Uses hearing aid [ ]
Comments:
_____
_____

GENERAL HEALTH

Has the following condition(s):

Diabetes	[ ]	Fainting Spells	[ ]
Epilepsy	[ ]	Heart Condition	[ ]
Migraines	[ ]	Asthma	[ ]
Hyperactive (ADHD)	[ ]		

Allergies [ ] *(describe)* _____
_____

Allergic to bee stings [ ] *(describe)* _____
_____

Other [ ] _____
_____

Has a life threatening medical condition [ ]
Explain _____
_____

By signing below, the parent(s)/guardian(s) certify under penalty of perjury that the information given on this form is true and accurate.

_____ _____
Parent/Guardian Signature Date