

THE MONTESSORI SCHOOL OF HERNDON
Emergency Release Form

CHILD'S NAME: _____ DOB _____

PARENTS' NAMES: _____

PARENTS' ADDRESS _____

HOME PHONE: _____ E - MAIL _____

BUSINESS PHONE (Mother) _____ Cell _____

BUSINESS PHONE (Father) _____ Cell _____

INSURANCE COMPANY _____ Policy Number _____

NAME OF CHILD'S DENTIST _____ Phone: _____

NAME OF CHILD'S PHYSICIAN _____ Phone: _____

In the event of sickness or accident if the parent, guardian, in your physician of your dentist cannot be reached, may we use our physician or dentist? And / or the nearest hospital? _____

ANY SPECIAL PROBLEMS OR ALLERGIES? _____

ALLERGIC TO ANY MEDICATION(s) _____

ALLERGIC TO ANY FOODS _____

SYMPTOMS OF THIS ALLERGY _____

ACTION TO BE TAKEN _____

2 EMERGENCY CONTACTS OF LOCAL ADDRESS: (other than parents):

NAME: _____ Address: _____

City _____ State _____ ZIP _____

Work# _____ Home# _____ Cell# _____

NAME: _____ Address: _____

City _____ State _____ ZIP _____

Work# _____ Home# _____ Cell# _____

The school has my permission in an emergency, when I or my dentist or physician cannot be contacted to take my child to the nearest dental office or to the emergency room of the nearest hospital and the dentist or hospital staff has my permission and authority to give emergency care when a physician deems it necessary for the well being of the child. I understand that I am responsible for all cost that may incur in providing my child with the needed emergency care due to an illness or an accident on school premises. I am also responsible for all hospital, medical and / or dental bills for long term care due to illness or accident on school premises. I understand that the school is not financially responsible for any hospital, ambulance, medical or dental care cost of my child.

Signature of Director

Signature of Parent or Guardian

Date