

**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

Parent or Guardian's Signature

\_\_\_\_\_  
Date: \_\_\_\_\_

\_\_\_\_\_  
Date: \_\_\_\_\_

Time of Program: \_\_\_\_\_ to \_\_\_\_\_ Start date: \_\_\_\_\_ Class: \_\_\_\_\_