The Montessori School of Herndon

2024/2025

Emergency Release Form

A new Emergency Release Form is required at the start of each school year. During the school year, you MUST update your form if contact information changes at any time, if your child develops allergies or medical conditions we should be aware of, or to add/remove authorized individuals. **Please complete all fields on both sides. Enter "No" or "N/A" if it does not apply.**

Child's Name:	DOB:
Address (Street, City, State, Zip Code):	
Parent's Name:	Email:
Business Phone:	Cell Phone:
Parent's Name:	Email:
Business Phone:	Cell Phone:
Insurance Company:	Policy Number:
Dentist:	Phone:
Physician:	Phone:
Preferred Hospital:	

In the event of sickness or an accident, if the parent/guardian, or your physician or dentist, cannot be reached, may we use our physician, dentist, and/or the nearest hospital? **YES / NO**

Medical Issues:
Medical Allergies & Reaction:
Food Allergies & Reaction and/or Food Restrictions:

Emergency Contacts:

In the event of an emergency, MSH is authorized to contact the following individuals, if the custodial parents/guardians cannot be reached. **You must provide at least TWO contacts with LOCAL addresses (other than the parents).**

1. Name:	
Address (Street, City, State, Zip Code):	
Business Phone:	Cell Phone:

2. Name:	
Address (Street, City State, Zip Code):	
Business Phone:	Cell Phone:

Authorized Pick-Up:

I authorize the additional individuals to pick-up my child from school:

1._____

2._____

3._____

I give my permission to The Montessori School of Herndon, when I or my physician cannot be reached, to take my child to the nearest dental office or to emergency care, when a physician deems it necessary for the well-being of my child. I understand that I am responsible for all of the costs that may be incurred in providing my child with the needed emergency care, due to an illness or an accident on school premises. I understand that the school is not financially responsible for any hospital, ambulance, medical or dental care costs for my child.

_____ _____

Parent/Guardian's Signature Date

For Office Use:

_____ _____

Director Date

Time of Program: _____ _____ _____

Days Start Date Class