

**MAIN STREET MONTESSORI & MIDDLE SCHOOL
EMERGENCY CONTACT & MEDICAL INFORMATION**

Child's Name:		Date of Birth:	Sex: M F
Parent's/Guardian's Name:		Parent's/Guardian's Name:	
Home Phone: ()	Work/Cell Phone: ()	Home Phone: ()	Work/Cell Phone: ()
Street Address:		Street Address:	
City, State, Zip Code:		City, State, Zip Code:	

ALTERNATIVE EMERGENCY CONTACTS

Primary Emergency Contact:		Secondary Emergency Contact:	
Home Phone : ()	Work/Cell Phone: ()	Home Phone: ()	Work/Cell Phone: ()
Street Address:		Street Address:	
City, State, Zip Code:		City, State, Zip Code:	

MEDICAL INFORMATION

Dentist:	Phone Number: ()
Address:	
Hospital/Clinic Preference:	
Physician's Name:	Phone Number: ()
Address:	
Insurance Company:	Policy Number:
Allergies/Special Health Considerations:	

In the event that neither parent/guardian can be reached in the case of an emergency, I hereby authorize all dental, medical and surgical treatment and care performed or prescribed by the attending physician and/or paramedics for my child. I agree to pay all costs and fees contingent on any emergency medical or dental care or treatment for my child. Every effort will be made to notify parents immediately in case of an emergency.

Parent's/Guardian's Signature:	Date:
I give permission for my child to be given acetaminophen when deemed necessary and appropriate by a Main Street Montessori & Middle School facilitator. Notification of administration will be provided to parent(s)/guardian(s).	
Parent's/Guardian's Signature:	Date: