COUNTRYSIDE MONTESSORI CHARTER SCHOOL

Student Emergency Form 2021 - 2022

Student Name: ____ D.O.B.: _____________ Grade: _______ Sex: M F
Last First MI
Address: ____ City, State, Zip: ____________________________________

Student lives with: ☐ Both Parents ☐ Father ☐ Mother ☐ Guardian ____
Relation to Attending Student

	Mother/Guardian	Father/Guardian
Name (First and Last)		
Address (Street, City and Zip)		
Cell Phone Number		
Employer and Phone Number		
Home Number/Alternate Number		
E-mail Address		

ALTERNATE CONTACTS

Please list persons **other than the parent/guardian** that the school can reach should your child need medical treatment for illness, injury and authorized for pick up. **Please complete all contacts below**. NOTE: In the event of an emergency or disaster, the parent/guardian will be phoned first.

Name	Phone Number	Relationship	May Pick Up? Yes or No
1.			
2.			
3.			
4.			
5.			

MEDICAL INFORMATION

Physician's Name: ____ Phone:____
Dentist's Name: ____ Phone: ____
Hospital Preference: ____ Phone: ____
Please assist the Health Services Department to better serve your child by answering the following questions:

Has your child had any of the following:

	Yes	No
Diabetes	☐	☐
Seizures	☐	☐
If yes, date of last seizure______________		
Asthma	☐	☐

Current medical diagnosis/conditions: ______________
____
Allergies:
____

Does your child need or use:

	Yes	No
Glasses		☐
Hearing Aids	☐	☐
Assistive Devices (Wheelchair, brackets or braces)	☐	☐

Medication(s):
☐ at school_________________________________
☐ at home__________________________________

Has your child ever had any serious accidents, operations, or hospitalizations? ☐ Yes ☐ No
Does your child require any medical services at school? ☐ Yes ☐ No
If you have answered yes to any questions above, please explain:
____
____

By signing below, I give authorization for my child to have basic health screenings at school. If you choose not to allow your child to have these screenings, please send written notification to the front office.

In case of accident, serious injury, or illness, I understand first aid will be rendered in accordance with local school practices. If I am unable to be reached by phone, please call the doctor(s) listed or transport my child to any available medical facility. I agree to pay all medical expenses incurred in the handling of this emergency care. In case of an accident or illness where immediate treatment of my child is not indicated, but where he/she is unable to remain at school, I request that one of the persons listed on this form be contacted and requested to care for my child until I can be reached.

By typing my name below, I agree to the above terms and to confirm my acceptance of those terms.

______________________________________ ___________________
Print – Parent/Guardian Name Date

Special Health Concern(s): ____

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