PLEASE COMPLETE BOTH SIDES OF THIS FORM **2021-2022**

Name of child _____

Birthdate _____

Address _____

City _____ State _____ Zip _____

Father/Legal Guardian's Name	Mother/Legal Guardian's Name
E-mail address	E-mail address
Home Address (if different)	Home Address (if different)
City State Zip	City State Zip
Home/Cell Phone Work	Home/Cell Phone Work
Employer	Employer
Address	Address
City State Zip	City State Zip
Employer Phone Hours	Employer Phone Hours

Names of 3 people to be notified in an emergency when parent is not available. These people are also authorized to pick up my child from school.

Name	Relationship	Phone/Cell
Address	City State Zip	
Name	Relationship	Phone/Cell
Address	City State Zip	
Name	Relationship	Phone/Cell
Address	City State Zip	

If your child were to attend public school, what district and building would he/she be in: _____
District / Building

PLEASE COMPLETE EITHER PART I OR PART II BELOW

Part I: Permission to transport and treat child

In the event reasonable attempts to contact me have been unsuccessful, I give permission to The Montessori School of Wooster to secure emergency transportation and treatment for my child.

_____ _____
Signature of parent or legal guardian Date signed

Part II: Refusal to grant permission

I do not give permission to The Montessori School of Wooster to transport my child for emergency medical or dental care. In the event of an illness or injury which requires emergency treatment, I wish the following actions to be taken:

_____ _____
Signature of parent or legal guardian Date signed

Physician/Dental/Health History (all questions must be completed)

_____ _____
Name & Address of child's physician or health clinic Phone number

_____ _____
Hospital preferred for emergency treatment Health Insurance Policy (name & number)

Allergies & treatment, if any _____

Medications, food supplements, modified diet or fluoride supplements _____

_____

Chronic Physical Problem(s) _____

History of hospitalization _____

_____

Diseases this child has had _____

_____ _____
Name of dentist or clinic Phone number

_____
Street City Zip