

The CoOp Montessori Preschool – Emergency Contacts 2019-2020

Child's Information:

Child's Name:

Date of Birth:

Address:

City:

State:

Special Conditions, Allergies, Disabilities, Comforting Items, or Medical Emergency Information:

Parent/Guardian Information (1):

Parent/Guardian Name:

Relationship to Child:

(If different from child)

Address:

City:

State:

(Circle the most reliable #)

Home #:

Cell #:

Work #:

Preferred Email:

Place of Work:

Address:

Parent/Guardian Information (2):

Parent/Guardian Name:

Relationship to Child:

(If different from child)

Address:

City:

State:

(Circle the most reliable #)

Home #:

Cell #:

Work #:

Preferred Email:

Place of Work:

Address:

Additional Emergency Contact (1):

Name:

Relationship to Child:

Address:

City:

State:

(Circle the most reliable #)

Home #:

Cell #:

Work #:

Preferred Email:

Additional Emergency Contact (2):

Name:	Relationship to Child:
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Address:	City:	State:
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(Circle the most reliable #)

Home #:	Cell #:	Work #:
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Preferred Email:**Medical Information:**

Physician's Name:	Practice Name:
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Address:	City:	State:
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Phone #:**Dentist's Name:**

Address:	City:	State:
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Phone #:

Health Insurance Plan:	ID#:
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Subscriber's Name (on insurance card):**Parent/Guardian Consent and Agreement for Emergencies:**

As parent/guardian, I consent to have my child receive first aid by facility staff and, if necessary, be transported to receive emergency care. I will be responsible for all charges not covered by insurance. I consent for the emergency contact person listed above to ACT ON MY BEHALF until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months.

Parent/Guardian Signature:	Date:
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Parent/Guardian Signature:	Date:
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