

Student Information and Health Form

CHILD INFORMATION

Last	First	Middle	Date of Birth (mo/day/year)

PARENT(S)/GUARDIAN(S) CONTACT INFORMATION

We require this information to contact you for school business or emergencies. Your contact information (home address, home phone number and preferred email address) will be published in the parent directory that is provided only to the school community. Please place an 'x' to the right of any information that you do not wish to have published.

Last	First	Home Phone #	Cell Phone #	email
Last	First	Home Phone #	Cell Phone #	email
Home Address				

OTHER ADULTS AUTHORIZED FOR PICK-UP AND/OR EMERGENCY CONTACT

Please list, in order of preference, all persons who are authorized to pick up your child at school or that should be contacted in an emergency if we are unable to reach a parent/guardian. Your child will not be released to anyone not on this list, unless previous arrangements have been made. I authorize the people named below to pick-up my child from Indiana Montessori Academy. (If no box is selected, the default is that the contact is for both emergency and pick-up.)

				<input type="checkbox"/>	<input type="checkbox"/>
Authorized Pick-Up Name	Relationship	Cell Phone #	Other Phone #	Emergency	Pick-Up
				<input type="checkbox"/>	<input type="checkbox"/>
Authorized Pick-Up Name	Relationship	Cell Phone #	Other Phone #	Emergency	Pick-Up
				<input type="checkbox"/>	<input type="checkbox"/>
Authorized Pick-Up Name	Relationship	Cell Phone #	Other Phone #	Emergency	Pick-Up

HEALTH HISTORY/INFORMATION

Allergies	Current Medications	Dietary Restrictions (OR any foods you wish your child not to eat)			
Medical Condition OR Special Needs		Operations OR Serious Injuries		Last Immunization Date	
Physician's Name	Phone Number	Dentist Name	Phone Number		
Preferred Hospital		Insurance Policy		Policy OR Group #	

(If emergency warrants child will be taken to the closest hospital to the location of the injury.)

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel attending to my child to order X-rays, routine tests and treatment for my child, and, in the event I am not able to communicate or cannot be reached in an emergency, I hereby give permission to the attending physician to hospitalize, secure proper treatment for, and order injection(s) and/or anesthesia and/or surgery for my child as named above. I will be fully responsible for any costs of such treatment, even if not covered by insurance.

Parent/Legal Guardian (printed name)	Signature	Date