IMA | Indiana Montessori Academy
I M A child creating our future

2016- 2017 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.)*

Authorized Pick-Up Name | Relationship | Cell Phone # | Other Phone # | ☐ Emergency | ☐ Pick-Up

Authorized Pick-Up Name | Relationship | Cell Phone # | Other Phone # | ☐ Emergency | ☐ Pick-Up

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