FOUNDATIONS
CHRISTIAN MONTESSORI ACADEMY

Emergency Treatment and Transportation

_____

Child's Name *Child DOB* *Home Address*

Mother/Guardian Contact: _____ _____ _____

First and Last Name *Cell Phone #* *Work Phone #*

Father/Guardian Contact: _____ _____ _____

First and Last Name *Cell Phone #* *Work Phone #*

Pease check and/or list any medical condition your child may have:

☐Allergies ☐Asthma ☐Diabetes ☐Heart Condition

☐Other: _____

Allergies: _____

If allergic, what are signs/symptoms of allergic reaction? _____

Other Health Condition(s)/Concerns/Medications: _____

_____

_____

Pediatrician Name: _____ Dentist Name: _____

Insurance Information:

Provider: _____ Policy: _____ Group #: _____

Name of Insurance Holder: _____ Card Holder DOB: _____

Authorization for Medication

Disbursement of medication sent in from home is as follows: (1) all medication dispensed at Foundations Christian Montessori Academy requires a written authorization by the student's parent(s)/guardian; this includes over-the-counter medications (2) Completion of an Over-the-Counter Medication Authorization Form (3) Medication in the ORIGINAL container – Prescription meds in the original pharmacy labeled container (4) All meds must be delivered by the parent(s) to the Front Office. Medications should never be in the possession of the student, including backpack or lunch box.

Authorization for Emergency Medical Care

I understand that it is my responsibility to see that my child has regular medical examinations as required for attendance at Foundations Christian Montessori Academy; and that my child's immunizations are kept current as required by the State of Florida. In case of emergency, I/we authorize any representative of the Academy to present the above stated minor to receive any emergency care my child may need.

I give permission for Foundations Christian Montessori Academy to call my child's physician and/or dentist, as listed on Application for Enrollment, in the event of an emergency.

Preferred Hospital: _____ Authorize Ambulatory Transportation ☐Yes ☐No

_____

Mother/Legal Guardian's Printed Name *Mother/Legal Guardian's Signature* *Date*

_____

Father/Legal Guardian's Printed Name *Father/Legal Guardian's Signature* *Date*

On this date, the above person appeared before me and verified that he/she understands and agrees to the above stated parental permission for emergency medical treatment.

Dated the _____ day of _____, 20_____. Type of ID: Driver's License / Personally Known

Driver's License: State _____ # _____ County _____

Notary Public Signature _____ My Commission Expires: (Notary Seal/Stamp)