2022-2023 CALIFORNIA MONTESSORI PROJECT CHARTER SCHOOL MEDICAL AND EMERGENCY INFORMATION AND CONSENT

Student	Date of Birth: Sex: For Office Use Only:
Name:	Grade
Name of parent/guardian student resides with during school week:	
Name of parent/guardian student resides with during school week.	F 🗆 Class:
	Binary
Address:	
Primary Phone #: Circle Phone Type: Home/ Work/ Cell	Other Phone #: Circle Phone Type: Home/ Work/ Cell
1st Contact Parent (and allowed to transport student)	2nd Contact Parent (and allowed to transport student)
1 st Contact Parent (and allowed to transport student)	2 nd Contact Parent (and allowed to transport student)
Name:	Name:
Physical Address:	Physical Address:
	CitulZin
City/Zip:	City/Zip:
Primary Phone #: Circle Phone Type: Home/ Work/ Cell	Primary Phone #: Circle Phone Type: Home/ Work/ Cell
Other Phone #: Email:	Other Phone #: Email:
Business Name:	Business Name:
Business Address:	Business Address:
Business Phone #:	Business Phone #:
Additional Person who may be called and who may transport student	Additional Person who may be called and who may transport student
Name: Relationship:	Name: Relationship:
Address:	Address:
City/Zip:	City/Zip:
Primary Phone #: Circle Phone Type: Home/ Work/ Cell	Primary Phone #: Circle Phone Type: Home/ Work/ Cell
Secondary Phone #: Circle Phone Type: Home/ Work/ Cell	Secondary Phone #: Circle Phone Type: Home/ Work/ Cell
Other Phone#: Circle Phone Type: Home/ Work/ Cell	Other Phone #: Circle Phone Type: Home/ Work/ Cell

Any Legal Special Custody Arrangements: Please note below and provide a copy of legal court order.

PLEASE COMPLETE INFORMATION ON REVERSE SIDE

HEALTH INFORMATION

Please list any known health problems:
Specify symptoms which occur:
List any medications being taken by your child:
Does your child take medications prior to arriving at school? Yes No Name of Medication:
List known allergies: Requires Medication: Yes No
Does your child wear: Glasses? Yes No Contacts? Yes No Hearing Aid? Yes No
Please circle if your child has any of the following: Asthma Diabetes Dizziness Fainting Heart Disease
Heart Murmur Muscle, Bone, or Joint Injuries Epilepsy/Seizures
Does your child use an inhaler? Yes No
Does your child require Assistive Devices (wheel chair, etc.)? Yes No What type?
OR HOSPITAL CARE, INCLUDING NECESSARY TRANSPORTATION OF MY CHILD. UNDER SUCH CIRCUMSTANCES, I FURTHER AUTHORIZE SUCH CARE AND TREATMENT TO BE PERFORMED BY ANY LICENSED PHYSICIAN OR SURGEON. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL-BEING OF THE CHILD NAMED ABOVE. The undersigned hereby agrees to bear all costs incurred as a result of the foregoing. This authorization will remain in effect until revoked by the undersigned. Medical Insurance Carrier & Policy #:
Family Physician: If unavailable, alternative?
Address: Phone:
Family Dentist: If unavailable, alternative?
Address: Phone:
Hospital of choice when possible:
Parent/Guardian Signature: Date: