

Child's Name:
Child's Physician:
Physician's Address:
Physician's Telephone:

HEALTH RECORD (to be completed by parent/guardian)

Date: _____ Age: _____ Telephone No: _____

TO BE FILLED OUT BY PARENT OR GUARDIAN:

Child's Medical History - Please indicate any occurrence of a significant illness, childhood disease or surgery for the child (Include age):

Does the child have any significant allergies? _____ If so, what are they?

Is the child on any medication? Yes No
Is so, what kind?

Does the child have any special problems such as vision, auditory, speech, muscle coordination, etc.? Yes No
If yes, what are they?

Please give the dates and doctor used for the problem:

Has your child had a Tuberculin skin test? Yes No Results: _____

Please explain any pertinent medical problems in brothers, sisters, mother, father, grandparents:

***Please attach a copy of child's birth certificate
(First time applicants only)***

EMERGENCY CONTACTS with PERMISSION TO REMOVE CHILD from PREMISES

New England School of Montessori must have written permission on file for any and all persons who may pick up your child from NESM. Positive photo identification of unfamiliar persons must be given. Children will not be released to anyone under 18 years of age.

The following persons are authorized to pick up my child, should the school be unable to contact us in the event of an emergency, we suggest that one of the following be contacted:

Name: _____ Relation to Child: _____

Address: _____

Telephone numbers:

(home) _____ (work) _____ (cell) _____

Name: _____ Relation to Child: _____

Address: _____

Telephone numbers:

(home) _____ (work) _____ (cell) _____

Name: _____ Relation to Child: _____

Address: _____

Telephone numbers:

(home) _____ (work) _____ (cell) _____

Name: _____ Relation to Child: _____

Address: _____

Telephone numbers:

(home) _____ (work) _____ (cell) _____

Signature of parent or guardian

Date: _____

AUTHORIZATION FOR EMERGENCY CARE TO A MINOR

I/We, the undersigned, parents or legal guardian of the minor listed below:

(Minor's Name) _____

Birth Date: _____

Do hereby authorize First Aid trained staff of New England School of Montessori to offer first aid to _____ AND do hereby authorize any necessary transportation to the nearest hospital by EMS or any other licensed emergency transport service (Parents are responsible for payment of the ambulance transportation fee) or any X-ray, anesthetic, dental, medical or surgical diagnosis or treatment by any physician or dentist licensed by the State of Connecticut or hospital service that may be rendered to said minors under the general, specific or special consent of the New England School of Montessori staff (trained in First Aid), the temporary custodians of the minor whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at a hospital licensed by the appropriate licensing bureau or elsewhere as required by the emergency nature or the situation. I/We authorize the physician or dentist to call in any necessary consultants in his/her/their discretion.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required but is given to encourage those persons who have temporary custody of the minor and any attending physician or dentist to exercise his/her best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment.

The minor's customary physician and dentist are:

Name of Physician: _____

Address: _____

Telephone: _____

Name of Dentist: _____

Address: _____

Telephone: _____

Mother or Father or Legal Guardian signature: _____

Date: _____ Head of School signature: _____

This form authorizes a physician or dentist to provide necessary care to a child whose parents are not immediately available. The form should be left with the adult to whose care the child is entrusted in the parent's absence.