



Alfred Montessori School Emergency Medical Permission

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Relationship: _____

Address: _____

Primary Phone: _____ Alt. Phone: _____

Employer: _____ Work Phone: _____

Allergies: _____

Known medical conditions: _____

Child's Physician: _____

Insurance Carrier: _____

Identification Number: _____

Note: The Alfred Montessori School does not provide medical insurance for the students enrolled in the program. If your child is injured during the school day and requires medical attention, the parents are responsible for payment.

I hereby certify that I have authorized the staff of the Alfred Montessori School to obtain any emergency care for my child in the event of an accident or illness requiring health care.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____