Canton Montessori School
Health Record & Emergency Medical Authorization

Please PRINT

Name of Child _____ Date of Birth _____ Name of Parent _____

I Allergies (List all allergies affecting the child and any special precautions or treatments indicated for these allergies)

_____

II Medications or Food Supplements (list all medications or food supplements currently being administered to the child)

_____

III Dietary Restrictions (List all modified dietary restrictions affecting the child) _____

_____

IV Chronic Physical/Development Concerns (List all chronic problems affecting the child) _____

_____

V History of Hospitalization (List dates of all hospitalizations) _____

_____

VI Diseases (List all diseases the child has had) _____

_____

VII Any other concerns (List any learning, emotional, social, etc…concerns that will help CMS serve your child)

_____

_____

Your Signature: _____ **Date form complete:** _____

Emergency Medical Authorization

A. Complete the following:

_____ Name of Child	_____ Parent Name	_____ Parent Name
_____ Street Address	_____ Home Address	_____ Home Address
_____ City, State, Zip	_____ City, State, Zip	_____ City, State, Zip
_____ Telephone Number	_____ Telephone Number	_____ Telephone Number
List additional children in school to be named on this form:	_____ Cell Phone Number	_____ Cell Phone Number
_____	_____ Employer's Name	_____ Employer's Name
_____		
_____	_____ Employer's Telephone Number	_____ Employer's Telephone Number
	_____ Employer's Address	_____ Employer's Address

OVER

B. List three (3) people who can be contacted in an emergency if the parents can not be reached, in the order the calls should be placed: *(Please provide phone numbers which are <u>specific</u> to that contact – this will enhance our ability to reach someone in an emergency)*

_____ Name	_____ Name	_____ Name
_____ Address	_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip	_____ City, State, Zip
_____ Telephone Number	_____ Telephone Number	_____ Telephone Number
_____ Alternate Telephone Number	_____ Alternate Telephone Number	_____ Alternate Telephone Number
_____ Relationship To Child	_____ Relationship To Child	_____ Relationship To Child

C. Either Part I or Part II below MUST be completed. DO NOT COMPLETE BOTH. *This form authorizes CMS to secure emergency transportation/provide first aid or medication for a child.*

<u>Part I To Grant Consent</u>

I hereby give consent for the following medical care providers and local hospital to be called:

_____ Name of Physician or Clinic	Street Address	City, State, Zip	Phone Number
_____ Name of Dentist or Clinic	Street Address	City, State, Zip	Phone Number
_____ Name of Medical Specialist	Street Address	City, State, Zip	Phone Number

_____
Preferred Hospital

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____ _____
Parent Signature Date

<u>Part II Refusal to Consent</u>

I do NOT give my consent for emergency medical treatment of my child. In the event of an illness or injury, which requires emergency medical treatment, I wish the school authorities to take the following action:

_____.

_____

_____

_____ _____
Parent Signature Date