Hudson Country Montessori School

340 Quaker Ridge Road, New Rochelle, NY 10804
Phone: (914) 636-6202) / Fax: (914) 636-5139

Medical Emergency / Release Form

School Year 2019/20 & Summer 2019

Child's Full Legal Name_____ **Home Phone #**_____

Release Information

I,_____, accept full responsibility for my child, _____, while traveling to and from Hudson Country Montessori School. The people listed below on the Emergency Release section are authorized to drop off and pick up my child. I understand that my child will not be released to any other persons without my written consent. I also understand that unless the school has received a court order to the contrary, both parents have legal authorization to pick-up their children at any time.

Medical/Emergency Information

I, _____, give Hudson Country Montessori School permission to take whatever emergency measures (*e.g.* first aid, disaster evacuation) that are judged necessary for the care and protection of my child while under the supervision of the School. In the case of a medical emergency, I understand that my child may be transported to an appropriate medical facility either by the School or by a local emergency unit if it is deemed necessary. Any expenses incurred will be my responsibility. I understand that in some medical situations, the School will need to contact the local emergency resource before either parent, the child's physician, and/or the other emergency contacts listed on this form.

Parent 1/Guardian _____

Home # _____

Work # _____

Cell # _____

Parent 2/Guardian _____

Home # _____

Work # _____

Cell# _____

Emergency/Release Names:

Name:_____
Circle One: Emergency Release Both

Phone #_____

Work # _____

Cell # _____

Emergency/Release Names:

Name:_____
Circle One: Emergency Release Both

Phone # _____

Work # _____

Cell # _____

Name:_____
Circle One: Emergency Release Both

Phone #_____

Work # _____

Cell # _____

Name:_____
Circle One: Emergency Release Both

Phone # _____

Work # _____

Cell # _____

Physician _____ **Phone# (____)**_____

Dentist _____ **Phone# (____)**_____

Health Insurance Policy# _____ **Phone# (____)**_____

Health Insurance Carrier _____

Allergies (Including Food) _____

Medications and significant medical information: _____

_____

_____

_____

Signature of Parent / Guardian / Date