

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 \_\_\_\_\_

Parent 2/Guardian \_\_\_\_\_

Home # \_\_\_\_\_

Home # \_\_\_\_\_

Work # \_\_\_\_\_

Work # \_\_\_\_\_

Cell # \_\_\_\_\_

Cell# \_\_\_\_\_

**Emergency/Release Names:****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 # \_\_\_\_\_

**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