

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