Peninsula Montessori School

Child's name:			
D.O.B:	**Sex M or F**		**Home Phone:**
Address:			
Father's name:			
Father's work phone:			**Cell:**
Mother's name:			
Mother's work phone:			**Cell:**
Father's e-mail:			**Mother's e-mail:**
Alternate address:			

Alternate Emergency Contact

Name:	Address:	Phone:	Relationship:

Medical Emergency

Physician:	**Phone:**
Dentist:	**Phone:**

Persons authorized to take child from the facility (not listed above)

Name:	Relationship:

CONSENT FOR MEDICAL TREATMENT

As the parent/guardian, I hereby give consent to Peninsula Montessori School to provide all emergency dental or medical care prescribed by a duly licensed physician (M.D.) or dentist (D.D.S.) for my child. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my child.

CHILD HAS THE FOLLOWING:

MEDICATION:	ALLERGIES:

_____ _____

Parent/Guardian **Date**

SCHOOL DIRECTORY EXCLUSION

_____ **I would NOT like my child's name, parent's name, address, home phone, and e-mail address included in the school directory.**