

 Child’s Name

Portable Emergency Consent

Child’s Name Birth Date

Child’s Physician Location

Physician’s Phone Date of Last Exam (mm/dd/yyyy)

Child’s Dentist Location

Dentist’s Phone Date of Last Dental Exam (mm/dd/yyyy)

Is child on medication? □Yes □No List Medications, dosage, frequency

Allergies/Reaction/Treatment\*

Special Dietary Requirements/Food Restrictions

Serious Illnesses, Accidents or Surgeries (give dates)

Specific Health Problems

Parents Contact Information

MOTHER FATHER

Name Name

Day Phone Day Phone

Cell Phone Cell Phone

Home Phone Home Phone

Address Address

Authorized to Pickup Child: 🞐 YES 🞐 NO Authorized to Pickup Child: 🞐 YES 🞐 NO

Authorization to pickup child

Please list the additional people authorized to pick up your child from Eyas Global Montessori:

Name Name

Phone Phone

Relationship to Child Relationship to Child

Name Name

Phone Phone

Relationship to Child Relationship to Child

Name Name

Phone Phone

Relationship to Child Relationship to Child

Please complete the back side of this document.

Primary Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TWO LOCAL EMERGENCY CONTACTS (other than parents)

Name Name

Phone Phone

Relationship to Child Relationship to child

Authorized to Pickup Child: 🞐 YES 🞐 NO Authorized to Pickup Child: 🞐 YES 🞐 NO

CONSENT FOR TREATMENT

I hereby give permission that my child,

may be given emergency treatment by a qualified staff member of Eyas Global Montessori. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

In the event that I cannot be contacted, I further consent to medical, surgical and hospital care, treatment, and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child’s health.

Preferred Hospital

Signature

Today’s Date

OUT OF STATE EMERGENCY CONTACT

Name

Phone

Area

Relationship to Child

\*Children with allergies are required to have a completed and signed Report of Food Allergy from their Heatlhcare Provider. For all other medical conditions a Health Care Plan is required completed and signed by your health care provider. Parents must supply their child’s snacks when allergies exist.

Authorized to Pickup Child: 🞐 YES 🞐 NO