

ALEXANDER GRAHAM BELL MONTESSORI SCHOOL
EMERGENCY INFORMATION and RELEASE CARD 2024-25



Child's Name _____
First Middle Last M - F Date of Birth

Address _____ City _____ Zip _____ Home phone _____

Mother's Name _____ Father's Name _____

Mother's Employer _____ Father's Employer _____

Mother's Business Phone _____ Father's Business Phone _____

Address _____ Address _____

Cell # _____ Home # _____ Cell # _____ Home# _____

E-mail address _____ E-mail address _____

Program Selected: _____ infant/toddler _____ CH _____ ELE _____ Middle _____ full days _____ half days

_____ After School Activities _____ AM Care _____ PM Care

_____ Special Needs or Diet Restriction _____

Office Use Only: **School Year 2024-25** Start Date _____ End Date _____ Transfer _____
Classroom _____ Transparent login _____

Please print legibly

TO WHOM IT MAY CONCERN:

In the event that I am unable to be reached, I hereby authorize the bearer, who is a member of the staff of Alexander Graham Bell Montessori School, to sign on my behalf any and all forms required in order to obtain emergency treatment provided by you to my child. I realize that I am responsible for payment for such emergency care. A photocopy of this Authorization and Consent for Medical Treatment shall have the same force and effect as the original. AGBMS has been provide a current copy of child's health insurance coverage.

Child's Name _____ Hospital Name _____

Doctor's Name _____ Doctor's Phone # _____

Insurance Name _____ Insurance & ID # _____

ALLERGIES or existing medical conditions: _____

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

Name _____ Phone Number _____

Name _____ Phone Number _____

Please list below all persons authorized to pick up your child (including parents)

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Parent/Guardian Signature(s): _____