ALEXANDER GRAHAM BELL MONTESSORI SCHOOL
EMERGENCY INFORMATION and RELEASE CARD 2026-2027

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 2026-27*** *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): _____ _____