



AUTHORIZED STUDENT RELEASE

I/We authorize the following person(s) to pick up my/our child

from school.(Center Grove Montessori)

Name

Relationship

Contact Information

Parent

Signature

Date



EMERGENCY MEDICAL CARE FORM

Child's Last Name First M.I. Gender
_____ M/F_____

Date of Birth _____

Home Address _____

Home Phone _____

Cell phone _____

Pediatrician _____

Office Address _____

Office Phone _____

MEDICAL CARE RELEASE STATEMENT

I/We,

, authorize the Center Grove Montessori School to obtain emergency medical care for my /our child,

in the event of a medical emergency.

Parent Signature _____ Date _____



EMERGENCY CONTACT INFORMATION

Please provide parent contact information as well as two alternative contacts.

Child's name _____ DOB _____

Mother's Name _____

Work # _____ Cell # _____

Father's Name _____

Work # _____ Cell # _____

Alternate Contact#1 _____ Relation _____

Alternate Contact#2 _____ Relation _____

MEDICAL CONDITIONS

Please indicate any known allergies and other medical conditions

Condition _____ Prescribed Treatment (if any) _____

Parent Signature (mother)

Parent Signature (father)

Date _____