Mountain View MONTESSORI School

License number 6032 P.O. Box 495,INTERVALE, NH 03845 www.mvmontessori.com

Child's Health Information Form

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

Does child have any disabilities or physical restrictions? _____

Does child have any allergies or diet restrictions? _____

Does your child have health insurance coverage? ___ yes ___ no If so, with what company? _____

MEDICAL INFORMATION

Any chronic conditions, allergies or medications that could be important in case of sudden illness or injury: _____

Child's Usual Physician: _____ Phone number: _____

Physician's business name or affiliation: _____

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

I hereby give permission for the staff of Mountain View Montessori School to provide simple first aid treatment to my child, _____when necessary. In the event of a more serious illness or injury, I give permission for my child to be transported to a hospital or other emergency medical facility to receive emergency medical treatment. I also authorize ambulance/rescue squad attendants to administer such treatment as is medically necessary, and I authorize licensed health practitioners working in the hospital or emergency medical facility to examine and provide emergency medical treatment to my child if warranted. I understand that I will be contacted by child care program personnel as soon as possible regarding any emergency involving my child.

_____

Parent/Guardian Signature **Date**

ANNUAL UPDATE:

PARENT/GUARDIAN MUST REVIEW THIS INFORMATION **ANNUALLY**, MAKE NECESSARY CHANGES & INITIAL & DATE BELOW TO VERIFY THAT THE INFORMATION IS CURRENT.

Parent/Guardian Initials: Date:	Parent/Guardian Initials: Date:
Parent/Guardian Initials: Date:	Parent/Guardian Initials: Date: