North Hill Montessori School

Emergency Contact Information

Child's Name: _____ Date of Birth: _____ Sex: _____

Child's Address: _____

Mother or Guardian

Name: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Work Name: _____

Work Address: _____

Work Phone: _____

Father or Guardian

Name: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Work Name: _____

Work Address: _____

Work Phone: _____

Physician's Name: _____ Phone: _____

Physician's Address: ___ _____

Emergency contacts if parents cannot be reached:

1. Name: _____ 2. Name: _____

   Home Phone: _____ Home Phone:_____

   Business Phone: _____ Business Phone: _____

   Cell Phone: _____ Cell Phone: _____

   Relationship to child: _____ Relationship to child: _____

Person(s) other than parents authorized to pick up child from school.

1. Name: _____ 2. Name: _____

   Home Phone: _____ Home Phone: _____

   Cell Phone: _____ Cell Phone: _____

   Relationship: _____ Relationship: _____

I give permission for the operator, or designate, of North Hill Montessori School to take whatever steps are necessary to obtain emergency medical care if warranted.

Is there any special medical or additional information that would be helpful in an emergency?

_____

_____

Parent/Guardian Signature: _____ Date: _____