

WMS Emergency Information

Note: please inform the school of any changes immediately.

Child's name: _____ Age: _____ Date of Birth: _____ Sex ____
Home address: _____ Religion: _____
City _____ Zip _____ Phone: _____ Cell: _____
Child lives with: Father & Mother ___ Mother ___ Father ___ Other _____
Person(s) legally responsible for child: _____

Person(s) to be called in case of accident or illness who are authorized to pick up child:

Mother/guardian

Name: _____ Business phone & hours: _____ Home _____
Firm Name: _____ cell/pager: _____
Address: _____
Email Address _____

Father/guardian

Name: _____ Business phone & hours: _____ Home _____
Firm Name: _____ cell/pager: _____
Address: _____
Email Address _____

Alternate persons to be called if parents/guardians cannot be reached (local residents only) You are authorizing these people to pick up your child.

Name: _____ Relationship: _____ Phone: _____
Address _____ cell: _____

Name: _____ Relationship: _____ Phone: _____
Address: _____ cell: _____

Doctors to be called in an emergency:

Physician _____ Dentist _____
Name : _____ Name: _____
Address: _____ Address: _____
Phone: _____ Phone: _____
Child's regular doctor? _____

I hereby give my consent to windmill Montessori School to administer First Aid, to authorize a medical doctor to examine or treat my child, _____, to authorize necessary emergency treatment at a nearby medical facility, and /or to order ambulance transportation for my child while he/she is at WMS and /or off campus activities. I agree to accept the financial responsibilities for any and all costs incurred in the treatment of any illness, accident or injury of the above named minor.

Parent Name Signature Date