

EMERGENCY TRANSPORTATION AUTHORIZATION

Please fill this document out *completely on both sides*, as this information is shared with paramedics and emergency personnel in the event of an emergency!

BE SURE TO UPDATE THIS FORM IN THE SCHOOL OFFICE IF/WHEN INFORMATION CHANGES.

Child's Name	Parent/Mother's Name	Parent/Father's Name
Street Address	Street Address	Street Address
City, State, and Zip Code	City, State, and Zip Code	City, State, and Zip Code
Telephone Number	Telephone Number	Telephone Number
Child's Birth Date	Employer's Name	Employer's Name
Other phone number or pager where parent/mother can be reached during the school day.	Employer's Address	Employer's Address
Other phone number or pager where parent/father can be reached during the school day.	Work Telephone Number	Work Telephone Number

Please list three different people (with different addresses and phone numbers) who can be contacted during school hours if parent cannot be reached:

Name	Name	Name
Street Address	Street Address	Street Address
City, State, and Zip Code	City, State, and Zip Code	City, State, and Zip Code
Telephone Number	Telephone Number	Telephone Number
Relationship to the Child	Relationship to the Child	Relationship to the Child

Please complete **all** information for your child's **doctor and dentist** for ALL age children.

Name of Physician or Clinic	Name of Dentist or Clinic	List any known allergies or conditions that might be relevant in a medical or dental emergency.
Street Address	Street Address	
City, State and Zip Code	City, State and Zip Code	
Telephone Number	Telephone Number	

I, _____, give The Montessori School at Holy Rosary my permission to transport my
(please print) (circle one)
 child, _____, to _____ for emergency medical care
(please print child's full name) (name of hospital or clinic)
 or to _____ for emergency dental care, or to the nearest available assistance.
(name of dentist or clinic)

Parent's Signature	Date
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This form only authorizes the school to secure emergency transportation for a child. This form does NOT authorize or guarantee treatment upon arrival at the designated source of emergency medical or dental treatment, as each emergency facility sets their own treatment procedures.

PLEASE TURN OVER AND COMPLETE OTHER SIDE

ENROLLMENT INFORMATION 2010-2011

****This form must be filled out *completely* in the event of emergency medical treatment or transportation!****

- **THIS MUST BE COMPLETED BY PARENT/GUARDIAN.**
- **PLEASE DO NOT LEAVE THIS SIDE BLANK OR ATTACH ANY INFORMATION.**
- **ALL REQUIRED INFORMATION MUST BE COMPLETED ON THIS FORM.**

Child's full name: _____ Date of Birth: _____

Detailed Immunization Record: (Please use full dates)

VACCINE	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DtaP, DTP, or DT (Pediatric)					
HIB					
Polio Vaccine					
MMR					
Hepatitis B					
Varicella/Other (chicken pox)					

IMMUNIZATION SCHEDULE PER STATE OF OHIO LAW.

<u>Preschool children need:</u>	<u>Kindergarten children need:</u>	<u>1st grade children need:</u>	<u>2nd-8th grade children need:</u>
4 doses of DtaP, DTP, or DT	4 doses of DTaP, DTP, or DT	4 doses of DtaP, DTP or DT	4 doses of DtaP, DTP or DT
3 or 4 doses of HIB	3 doses of Polio Vaccine	3 doses of Polio Vaccine	3 doses of Polio Vaccine
3 doses of Polio Vaccine	2 doses of MMR	2 doses of MMR	2 doses of MMR
1 dose of MMR	3 doses of Hepatitis B	3 doses of Hepatitis B	3 doses of Hepatitis B
3 doses of Hepatitis B	1 dose of Varicella or written statement claiming history of disease	1 dose of Varicella	

 Please list all **allergies** and any special precautions or treatment indicated for these allergies: _____

Please list any medications, food supplements, modified diets, or fluoride supplements currently being administered to your child: _____

Please list any diseases or medical conditions that your child has had: _____

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PLEASE COMPLETE BOTH SIDES OF THIS FORM