



License number 6032

P.O. Box 495,INTERVALE, NH 03845

www.mvmontessori.com

## Child's Health Information Form

Child's Name \_\_\_\_\_ Birth \_\_\_\_\_  
Last First Middle M F Date \_\_\_\_\_

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: