

# Emergency Contact

Each year we ask parents to fill out an updated Emergency Contact form. One part stays with the teacher and the other part is kept in the office. Thank you for helping us keep our contact information up to date and current.

## Monroe Montessori 2008-09 Emergency Contact Information

### TEACHER'S COPY

Student: \_\_\_\_\_ Parents: \_\_\_\_\_ Phone \_\_\_\_\_

Address City Zip \_\_\_\_\_ Work Phones: \_\_\_\_\_

Cell Phones: \_\_\_\_\_ Email address \_\_\_\_\_

To be able to receive a cell text message in case of school closure please include the name of your cell phone provider.

In case of sickness or other emergency and I am unavailable the following people are authorized to pick up my child from school.

Emergency contact name #1 & Phone: \_\_\_\_\_

Emergency contact name #2 & Phone: \_\_\_\_\_

Emergency contact name #3 & Phone: \_\_\_\_\_

Name of Doctor or clinic for primary medical care/dental care: \_\_\_\_\_

Known allergic reactions (medicinal)/Other special health concerns \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Policy # \_\_\_\_\_

I understand every effort will be made to contact me in the event of an emergency. I give permission for emergency transportation and treatment. I accept full financial responsibility for medically necessary emergency treatment and services as determined by medical personnel. My address and phone number are correct.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

## Monroe Montessori 2008-09 Emergency Contact Information

### OFFICE COPY

Student: \_\_\_\_\_ Parents: \_\_\_\_\_ Phone \_\_\_\_\_

Address City Zip \_\_\_\_\_ Work Phones: \_\_\_\_\_

Cell Phones: \_\_\_\_\_ Email address \_\_\_\_\_

To be able to receive a cell text message in case of school closure please include the name of your cell phone provider.

In case of sickness or other emergency and I am unavailable the following people are authorized to pick up my child from school.

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Emergency contact name #2 & Phone: \_\_\_\_\_

Emergency contact name #3 & Phone: \_\_\_\_\_

Name of Doctor or clinic for primary medical care/dental care: \_\_\_\_\_

Known allergic reactions (medicinal)/Other special health concerns \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Policy # \_\_\_\_\_

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Parent Signature \_\_\_\_\_ Date \_\_\_\_\_