



## EMERGENCY MEDICAL AUTHORIZATION FORM

Please verify EACH item below and complete and/or correct for our school records. Every field MUST have information or N/A in order for us to accept as complete.

<b>Student's Name</b>	Birth Date	Gender	20-21 Grade
Previous School	From	To	Elem School
Parent/Guardian 1 Name	Parent/Guardian 2 Name		
Address	Address		
City / State / Zip	City / State / Zip		
Home Phone	Home Phone		
Cell Phone	Cell Phone		
Work Phone / Ext	Work Phone / Ext		
Email	Email		
Occupation/Title	Occupation/Title		
Employer Name	Employer Name		
Physician's Name	Physician's Phone		
Hospital Preference	Insurance Company		
Policy #	Name Policy is Under		

<b>Custody Terms:</b> Appropriate paperwork, such as custody papers, shall be attached if a parent is not allowed to pick up the student.	Marital Status	Court Order Date	Custody
	Custody	Court Order on File?	Custody Notes

**Emergency Contacts:** List two LOCAL emergency contacts, other than parents. We must have complete addresses for both emergency contacts.

Contact 1 Name	Relationship
Full Address	Home Phone      Cell Phone
Contact 2 Name	Relationship
Full Address	Home Phone      Cell Phone
List Up To Four Individuals Who May Pick Up	
Who May NOT Pick Up	

**Allergies:** Indicate any allergies to food, medication, environment, etc.

Is your child prescribed Epinephrine (Y/N)?	Is your child prescribed other allergy medication (e.g., Benadryl) (Y/N)?
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**Other Medical Needs:** Indicate any other medical conditions (e.g., asthma, attention disorder), pertinent developmental information or special accommodations needed.

Is your child prescribed medication (e.g., inhaler, stimulants) (Y/N)?	
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**Special Food Needs:** Indicate any food restrictions (other than allergies) due to intolerance or religious preferences.

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**Personal Information and Media Release:** Indicate your preference below.

I grant permission for my child's name, my name, and my email address to be included in The Learning Village Montessori directory (Y/N):	
I grant permission for my child to be photographed or featured in any video, television, audio recording, or broadcast in association with The Learning Village Montessori that will be made available to:	
The Learning Village Montessori families (Y/N):	The public (Y/N):

We hereby authorize TLVM personnel to take whatever steps may be necessary to obtain emergency medical care for my child in the event of an emergency. The hospital and its medical staff have my authorization to provide any treatment which a physician deems necessary for the well being of my child.

Parent or Guardian Signature	Date	Parent or Guardian Signature	Date
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