



# Emergency Information

## Raab Montessori Academy

\*Please print

Student's Name: \_\_\_\_\_

Parent Name(s): \_\_\_\_\_

Please list two emergency contacts, other than the child's parents, within close proximity who will assume temporary care of your child if you cannot be reached.

1. \_\_\_\_\_  
Name Relationship to child/family

\_\_\_\_\_  
Address Phone

2. \_\_\_\_\_  
Name Relationship to child/family

\_\_\_\_\_  
Address Phone

In case of an accident every effort will be made to contact the parents of the child. However, if it is not possible to reach the parents, it may be necessary for the child to be taken to the hospital for emergency treatment.

If the school is unable to reach me, I hereby authorize Raab Montessori Academy to call the physician indicated below and to follow his instructions. If it is not possible to contact the physician, Raab Montessori Academy may take whatever action is necessary in obtaining emergency treatment for my child.

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

Name of Local Physician: \_\_\_\_\_

\_\_\_\_\_  
Address of Physician

\_\_\_\_\_  
Phone Number of Physician



# Medical Information

## Raab Montessori Academy

Child's Name: \_\_\_\_\_

Child's Health Care Provider: \_\_\_\_\_

Health Care Provider Phone: \_\_\_\_\_

Health Care Provider Address: \_\_\_\_\_

Name of Insurance Company/HMO: \_\_\_\_\_

Group #: \_\_\_\_\_ Identification #: \_\_\_\_\_

Subscriber's Name on Insurance Card: \_\_\_\_\_

Known Allergies (including medication): \_\_\_\_\_

Medication My Child is Taking: \_\_\_\_\_

List Special Conditions, Disabilities, Medical/Physical Restrictions, Medical Information  
for Emergency Situations: \_\_\_\_\_

I certify that my child is in good physical health and may participate in the normal activities of the program and has no conditions or specific needs that require specific accommodations, unless otherwise indicated in the medical information provided above or an attached Universal Health Record or a Care Plan for Children with Special Health Needs.

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