



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: _____