

EMERGENCY CARD

Student: _____ d.o.b. _____

Please provide a reliable phone number and **confirm best email here:**

EMERGENCY CONTACTS include address	Call 1 st #	Call 2 nd #
Parent/Guardian to call 1 st Address (Street, City, Zip)		
Parent/Guardian to call 2 nd Address (Street, City, Zip)		
Emergency Contact 1/Relationship Address (Street, City, Zip)		
Emergency Contact 2/Relationship Address (Street, City, Zip)		

Student may be released to Emergency Contacts in case of injury, illness, or other emergency when parents cannot be reached.

AUTHORIZED PICK-UPS if different than above	Call 1 st #	Call 2 nd #
Name & Relationship to child Address (Street, City, Zip)		
Name & Relationship to child Address (Street, City, Zip)		

PLEASE INFORM EVERYONE LISTED ABOVE OF OUR DROP OFF AND PICK UP PROCEDURES.

HEALTH HISTORY (injury, illness, or chronic conditions relevant to school activity):

ALLERGIES (food, meds, bees, seasonal):

DIET RESTRICTIONS (FMS is peanut and tree-nut free):

MEDICATION taken regularly at home:

EMERGENCY MEDICATION at school (addit. forms req'd):

Pediatrician: _____ **Ph:** _____

Address: _____

Dentist, if applicable: _____ **Ph:** _____

Preferred Hospital: Avista Exempla/Good Sam Boulder Community Hosp. Other:

CONSENT FOR EMERGENCY TREATMENT: I authorize the staff at Fairview Montessori to act accordingly in case of emergency, to call 911 before attempting to contact me, to administer first aid/CPR to my child, to call my child's doctors should the need arise, and to arrange for transport to a hospital or urgent care facility by ambulance. If I am unavailable, I give consent for my emergency contacts to act on my behalf until I can be reached and for FMS to take whatever action is necessary in their judgment for the health and safety of my child. I will not hold FMS financially or legally responsible for my child's emergency care and transportation. *Consent expires 1 year from date signed.*

By sending your child to FMS, you agree that you will notify us if your child has been exposed to or contracted an infectious disease, that your child may be excluded from school when ill or not well enough to participate, and that your child will receive an annual influenza vaccine by Nov 15.

Parent/Guardian Signature: _____ Date: _____