

Deer Path Montessori School
Paragon Village, 429 Route 46 East, Hackettstown, NJ 07840
908-498-0500 Fax: 908-498-0505

Emergency Contact Information

PLEASE PRINT CLEARLY

Child's Name _____ Birth date: _____

Address _____

Parent/guardian Name # 1: _____

Address if different: _____

Home Phone # (____) _____ Cell (____) _____ Work (____) _____

Parent/guardian Name # 2: _____

Address if different: _____

Home Phone # (____) _____ Cell (____) _____ Work (____) _____

Emergency contacts to whom child may be released if parent/guardian is unavailable. Emergency contacts should be reliable persons who are readily available and has transportation during your child's class time. This should be someone your child knows and who knows that in an emergency he/she may be called upon to pick the child up at school.

Name & relationship # 1: _____

Telephone #'s: Home (____) _____ Cell (____) _____ Work (____) _____

Name & relationship # 2: _____

Telephone #'s: Home (____) _____ Cell (____) _____ Work(____) _____

Child's Health Care Provider:

Name: _____ Phone # (____) _____

Address: _____

Child's Health Insurance:

Name of insurance plan _____ ID # _____

Subscriber's name on insurance card _____

List special conditions, disabilities, allergies, food needs or medical information for emergency situations:

List preference for transportation arrangement in an emergency (parents/guardians are responsible for all emergency transportation charges.):

Hospital preference: 1st choice _____ 2nd choice _____

Parent/Guardian Consent and Agreement for Emergencies

I/we state that we are the parent(s)/guardian(s) having legal custody of the above child and attest that the information given is correct. I give consent to have said child receive first aid by the Deer Path staff, and, if necessary, be transported to receive emergency care. I also authorize the Director or Director Designee to contact my child's health care provider to alert him/her to my child's situation. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above **to act on my behalf** until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months. In the event of accidental poisoning, I agree that my child may receive Syrup of Ipecac or an absorption remedy if, and as, directed by the Poison Control Center. Deer Path will not be responsible for complications that may occur as a results of false or missing information on this form.

Parent/Guardian Signature # 1 _____ Date: _____

Parent/Guardian Signature # 2 _____ Date: _____