

Medical Information

Student's Doctor: _____ Phone: _____

Address: _____

List any know allergies, as well as severity and treatment method: _____

List any physical or other limitations your child has and any special procedures to be followed in caring for your child: _____

List any medications student is currently taking, including dosage and frequency: _____

Note: Please return medication authorization form if your child is taking medications

Describe any special dietary restrictions: _____

List communicable diseases and/or serious illness or surgery which student has had: _____

In the event of an emergency, I would prefer my child to be treated at (check one):

Wellstar/Kennestone Hospital

Cartersville Medical Center

Wellstar/Paulding Hospital

Children's Healthcare of Atlanta at Scottish Rite

To the best of my knowledge, _____ is in good physical and mental condition and capable of active participation in all activities except for the following:

Signature of Parent/Guardian

Date

*****Please attach current copy of children's immunization form and insurance card.**

Authorization for Emergency Medical Care

I hereby give my permission to Hopewell Montessori School and the agents, officers, and servants thereof to choose and secure emergency medical treatment and for chosen doctor, hospital, or medical service to provide emergency medical care and/or surgery for my child, _____ . It is understood that every effort will be made to locate the parents/guardian, or one of the emergency contacts listed on this form before any treatment is sought. I agree to cover any expense incurred by such treatment.

Signature of Parent/Guardian

Date

