MEDICAL AND EMERGENCY INFORMATION

MONTECITO SCHOOL

1468 GRANT RD, LOS ALTOS, CA 94024

PHONE: (650) 968-5957; FAX: (650) 968-2052

EMAIL: admin@montecitopreschool.com; WEBSITE: www.montecitopreschool.com

CHILD'S/ENROLLEE'S FULL NAME: _____

EMERGENCY & MEDICAL INFORMATION:

PHYSICIAN'S NAME: _____ **PHONE(S):** _____

DENTIST'S NAME: _____ **PHONE(S):** _____

As the parent, agency representative or legal guardian, I hereby give consent to Montecito School to provide all emergency dental or medical care prescribed by a duly licensed physician or dentist for_____*(child's name)*. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of dependent/enrollee/child.

SIGNATURE:_____ **DATE:**_____

CHILD'S/ENROLLEE'S ALLERGIES (IF APPLICABLE):

Food(s): _____

Other Allergies:_____

SEVERITY: **Mild?** _____ **Severe?** _____ **Life Threatening?** _____

Please describe on the Teacher Information Sheet what a typical allergic reaction has been in the past and discuss allergies with your child's teachers.

Does the child require medication to be with him/her? Y____ N____

If yes, please see the Office for Medication Release Form & Allergy Action Plan to be completed by you and your child's physician & returned to School with the medication.

EMERGENCY CONTACT & PICK-UP INFORMATION:

Please list four (4) local contacts/people who may be contacted in case of an emergency AND the name(s) of person(s), other than parent(s) or guardian(s) listed above, authorized to pick up child/Enrollee from Montecito Preschool. Children WILL NOT be allowed to leave with any other person without written authorization from parent or guardian.

NAME:	CITY:	PHONE(s):	RELATIONSHIP:
1.			
2.			
3.			
4.			