Montessori Academy of Northern Colorado
- Education for Life -

Montessori Academy of Northern Colorado

General Information Form

Student's Name_____Nickname_____

Sex M☐ F☐ Birthdate_____ Age_____

Date of Enrollment_____Address_____

Hm PH _____Best mode of contact (check one): text:☐ Call:☐ email:☐

Father's Name_____Cell #_____ Wk Phone_____

Employer_____Work Address_____

email_____

Mother's Name_____Cell# _____Employer_____

Wk Address_____Wk Phone_____

email_____

In case of emergency and neither parent can be reached, our contact people are:

Name_____Name_____
Address_____Address_____

Hm#_____Wk#_____Hm#_____Wk #_____

Cell#_____best #_____Cell#_____best #_____

Household Members: name and relationship_____

Child Pick up Information> Persons authorized to pick up child (Must show photo ID)

Name_____Cell/home_____work_____

Name_____Cell/home_____work_____

Name_____Cell/home_____work_____

Name, address and phone of child's doctor_____

Name, address and phone of child's dentist_____

Hospital of preference, pick one

☐ **The Children's' Hospital**

13123 e 16th Av. Aurora, CO 80045

720-777-1234

Northern Colorado Medical Center

☐ **Banner Health. 1801 16th St Greeley, Co 80631**

970-573-7052

☐ **Other**_____

_____

_____

Chronic Medical Conditions_____

Does your child have a health care plan? _____If yes, the health care plan must be provided on or before the first day child is in care.

Is your child fully immunized?_____Completed immunization records must be provided on or before the child's first day in care.

Health History

(Chronic or Reoccurring)

Ear Infections_____

Diabetes_____

Heart Disease/Defect_____

Convulsion/Seizers_____

Asthma_____

Nosebleeds_____

Measles_____

Mumps_____

Allergies

(Nature of Reaction)

Hay Fever_____

Plant Poisoning_____

Insect Sting_____

Penicillin_____

Other Drugs_____

Animals_____

Food_____

Other_____

Flu/Flu Shot_____

Chicken Pox_____

Operations or serious injuries/date_____

Is the child on any medication? Explain: _____

If yes, please describe_____

Physical limitations_____Describe if yes_____

Dietary limitations_____Describe if yes_____

Vision_____Hearing_____

Are there any activities that your child should NOT participate in? If so please list

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Authorization for Emergency Medical Care:

I hereby give my permission to Montessori Academy of Northern Colorado to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide medical or surgical care for my child _____.

It is understood that the child care provider will make a conscious effort to locate the parents/guardians or the emergency contacts listed before any actions will be taken. If it is not possible to locate emergency contacts, treatment will not be delayed. I/we will accept the expense of emergency transpiration, medical or surgical treatment.

Parent/Guardian Signatures_____Date_____

Printed Name_____

Parent/Guardian Signatures_____Date_____

Printed Name_____