



EMERGENCY RELEASE INFORMATION

2007-2008

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Name of Student	Date of Birth	Home Phone
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Street	City	Zip Code
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Parent Name 1	Employer	Work Phone	Cellular/Pager
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Parent Name 2	Employer	Work Phone	Cellular/Pager
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If a parent can not be reached list two neighbors or nearby relatives who are authorized to pick up your child in an emergency

1.

Name	Address	Phone
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2.

Name	Address	Phone
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Physician / Medical Facility Name	Address	City, Zip	Phone
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Dentist / Facility Name	Address	City, Zip	Phone
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Insurance Carrier and Policy Number:

List any medical concerns the staff should be aware of in working with your child

EMERGENCY MEDICAL RELEASE: I request that school personnel contact me or the emergency contact persons if my child becomes ill or is injured while attending at Sunny Hollow Montessori. In the event you are unable to contact us, I hereby authorize school personnel to call the physician or medical facility indicated. I give Sunny Hollow consent to follow physician's recommended instructions and make whatever arrangements are deemed necessary.

In the event of **POISON INJECTION**, I understand Sunny Hollow staff will contact the Poison Control Center or a physician. I give permission for the staff to administer Syrup of Ipecac to my child if directed to do so by the authorities mentioned above.

Parent signature: _____