



HOPE MONTESSORI SCHOOL
4614 RAVENSWORTH ROAD
ANNANDALE, VA 22003
(703) 941-6836
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http://www.hopemontessori.org

EMERGENCY INFORMATION AND TRANSPORTATION FORM

CHILD'S NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ DATE ADMITTED _____

ALLERGIES, DRUG SENSITIVITIES, OR MEDICAL CONDITIONS which should be considered for the health and well being of my child, prior to the Emergency Medical Treatment:

ALLERGIC TO _____ SYMPTOMS _____

ACTION TO BE TAKEN _____

I understand that no Emergency treatment will be given without parental consent, except in a life-threatening situation. Since informed consent must be given at the time of the incident, I understand that I must leave numbers where I (or my spouse or a responsible adult designated by me) may be reached if the numbers below do not apply for the day.

IN THE CASE OF AN EMERGENCY DURING SCHOOL HOURS, WHEN MY CHILD IS AT HOPE MONTESSORI SCHOOL, I UNDERSTAND THAT THE FOLLOWING PROCEDURE WILL BE FOLLOWED:

1. THE SCHOOL WILL CONTACT THE PARENT:

Father's Work # _____ Mother's Work # _____
Cell # _____ Cell # _____

2. IF NEITHER PARENT IS AVAILABLE THE SCHOOL WILL CONTACT THE FOLLOWING PEOPLE:

PLEASE COMPLETE THE INFORMATION FOR BOTH THE NAMES:

1. NAME _____ Relation to child _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

2. NAME _____ Relation to child _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

3. EMERGENCY TRANSPORTATION:

THE SCHOOL WILL ARRANGE FOR EMERGENCY TRANSPORTATION, AN AMBULANCE TO TRANSPORT THE CHLD TO THE NEAREST EMERGENCY MEDICAL FACILITY IF NECESSARY. AT NO TIME WILL A STAFF MEMBER DRIVE MY CHILD UNACCOMPANIED BY ANOTHER ADULT.

4. PHYSICIAN /DENTIST:

THE SCHOOL WILL CONTACT MY CHILD’S PHYSICAN AND OR DENTIST:

CHILD’S PHYSICIAN:

Name: _____ Telephone # _____

Address: _____ City _____ State ____ Zip Code _____

CHILD’S DENTIST:

Name: _____ Telephone # _____

Address: _____ City _____ State ____ Zip Code _____

I FULLY UNDERSTAND THE AFOREMENTIONED EMERGENCY MEDICAL PROCEDURES AND HEREBY AUTHORIZE HOPE MONTESSORI SCHOOL TO FOLLOW THE ABOVE POLICIES.

PARENT’S SIGNATURE

DATE

In order to comply with both the Commonwealth and County Health Department regulations, this form must be completed and returned to the school on the first day. If any of the above information changes during the year, we ask that you notify us of any changes immediately.

THANK YOU.