

EMERGENCY ALERT/ RELEASE FORM

The information below will be used if your chi school closures, power outages and other em-	lld has an accident, sudden illness, medical emergency, ergency situations in school.
Child's Full Name: Sex:	_ Date of Birth:
Child's Home Address:	
Telephone:	
ease clearly print the information for the meth	nods by which you wish to be contacted
Parent #1: □Mother □Father □Foster	Parent #2: □Mother □Father □Foster
Name:	Name:
Home Phone #:	Home Phone #:
Cell Phone #:	Cell Phone #:
Home Address:	Home Address:
Email:	Email:
Employer:	Employer:
Business Address:	Business Address:
Business Phone #:	Business Phone #:
Work Hours/Day	Work Hours/Day
Guardian's Name:	
Address:	
If child is in foster care, agency holding g	juardianship:



46, Fox Meadow Road, Scarsdale, NY 10583

Worker assigned:	Address:
Telephone #:	Emergency#:
Emergency Contacts	
dismissed from day care earlies supervision until contact can be others whom you would like to be	is weather conditions or other school emergency, your child may be than his/her scheduled time. Your child will remain at school unde made, please indicate the names and phone numbers of designated be contacted in the day care emergency. Be sure to ensure these people are available
I agree to allow those listed to to (This form is invalid if not signed)	ransport my child to and from the Yellow Acorn Montessori
Parent Signature:	
Date:	



GOVERNMENT ISSUED PHOTO ID MUST BE INCLUDED WITH THIS FORM FOR ALL ADULTS LISTED ON THIS FORM (INCLUDING PARENTS)

Contact #1 Name:	Contact #3 Name:
Relationship to child:	Relationship to child:
Home Phone#:	Home Phone#:
Cell phone#:	Cell phone#:
Contact #2 Name:	Contact #4 Name:
Relationship to child:	Relationship to child:
Home Phone#:	Home Phone#:
Cell phone#:	Cell phone#:
emergency medical, dental, and	Policy #:
Medications (maintenance med	cations taken at home):
If your child does NOT presently t	ake medication, please check this box \square
If your child does take mediations	please complete the following information.
Name of medication(s):	
Dosage:	# Of Times per Day:



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Duration of Medication: (complete one):

Temporary: Indicate Start Date:

Continuous: (check the appropriate box)
Will this medication be administered regularly through the school year:

Yes

No

How is it controlled?

Describe allergic reaction:

Additional pertinent health information:

* If your child has an allergy to a common food, or other allergen, which may cause an anaphylactic reaction,

please have your physician fill on the medication consent form that must accompany any medication and arrange to supply the school with your child's medication. A form must be accompanied by you and your child's physician for each medication. All medications must be in their original containers with package inserts and

valid expiration dates. Prescriptions must be rewritten every six months.