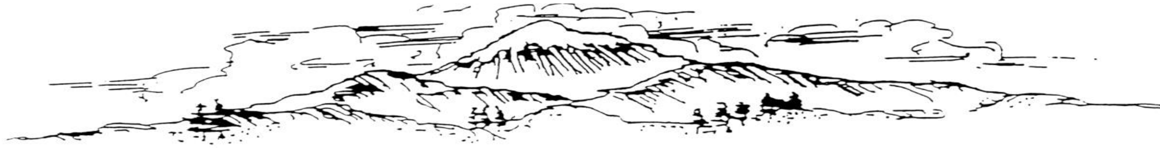


Children's House of Durango

Montessori Education

1689 West Third Avenue
Durango, CO 81301
970-259-1089

Date: ___________________________

AUTHORIZATION FORM

Authorization for emergency medical care must be obtained from the parent of each student. I/We __ ____ hereby given my/our permission to Children's House Staff to call a doctor for medical or surgical care for my/our child, ______________________________ should an emergency arise. It is understood that a conscientious effort will be made to locate me/us before emergency action will be taken, but if this is not possible, the expenses of emergency treatment or care will be accepted by me/us.

____
Parent/Guardian

____
Parent/Guardian

Emergency Phone Numbers:

Parent/Guardian Name: _____________________________

____________________ (Home) __________________(Cell) __________________(Work)

Parent/Guardian Name: _____________________________

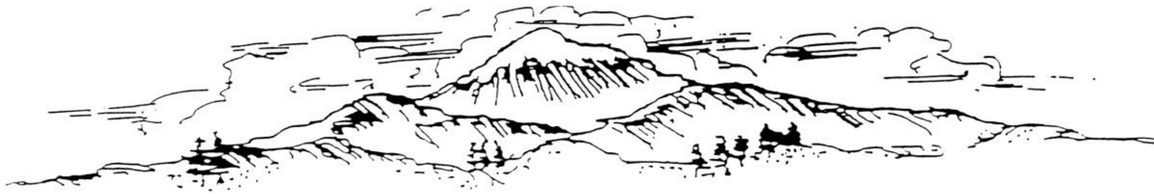
____________________ (Home) __________________(Cell) __________________(Work)

Backup Name: _______________________________

____________________ (Home) __________________(Cell) __________________(Work)

Name and number of child's physician: _____________________________________

Name and number of child's dentist: ____



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AUTHORIZED PICK-UP LIST

I hereby authorize the following people to pick up my child:

1. Name: ______________________________

___________________(Home)________________(Cell) __________________(Work)

2. Name: ______________________________

___________________(Home)________________(Cell) __________________(Work)

3. Name: ______________________________

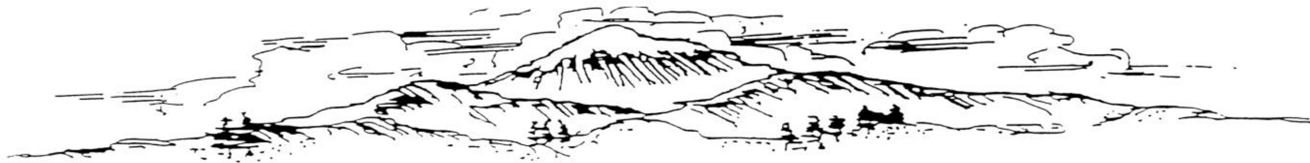
___________________(Home)________________(Cell) __________________(Work)

4. Name: ______________________________

___________________(Home)________________(Cell) __________________(Work)

I understand that my child __________________________________ will be released only to the persons on this list. The school must be contacted in writing to make any changes or additions to the authorized pick-up list.

Signature ___________________________ Date _____________



Children's House of Durango

Montessori Education
1689 West Third Avenue Durango, CO 81301
970-259-1089 (telephone & fax number)

CHILD'S MEDICAL STATEMENT

(To be completed by a licensed health care practitioner)

Child's name: ____________________________ Sex: ________

Child's age: ___________ Child's birth date: ____________________

Mother's name: __________________________ Father's name: ____________________________

Address: ____ Phone number: ________________

Surgery: ____

____

Accidents: ____

Illnesses: ____

____

Chronic Health Problems: ____

Describe any physical condition requiring the facility's special attention:

____

____

Allergies: ____
Vision exam results: ____
Hearing exam results: ____

Physical findings: ____

____

Comments and recommendations to child care personnel: __________________________________

____

***Please record immunizations and dates administered on the Colorado Department of Health Certificate of Immunization and attach to this form.**

Date: _______________ Provider's Signature: __________________________________

Provider's Phone: __________________________________