



The Franklin Montessori School

Forest Hills Campus

4473 Connecticut Avenue NW Washington, DC 20008

EMERGENCY FORM

Child's Name: _____ **Date:** _____

Parent 1: _____ **Telephone: (H)** _____ **E Mail** _____

(W): _____ **(Cell):** _____

Parent 2: _____ **Telephone: (H)** _____ **E Mail** _____

(W): _____ **(Cell):** _____

Instructions: Please list persons who are authorized to pick up your child in an emergency if you cannot be contacted. List these emergency contacts in the order you wish them to be called.

1. Name: _____
Last First

Telephone: (H) _____ **(W)** _____

Address: _____
Street/Apt. # City State Zip Code

Relationship to Child: _____

2. Name: _____
Last First

Telephone: (H) _____ **(W)** _____

Address: _____
Street/Apt. # City State Zip Code

Relationship to Child: _____

3. Name: _____
Last First

Telephone: (H) _____ **(W)** _____

Address: _____
Street/Apt. # City State Zip Code

Relationship to Child: _____

Instructions: Complete the following items, as appropriate, if your child has a condition(s) that might require medical care. If necessary, have your child's health practitioner review the information you provide below.

Medical Condition: _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

Has your child been stung by a bee? YES NO

Reaction? _____

Emergency Medical Instructions

1. Signs/symptoms to look for: _____

2. If Signs/Symptoms appear, do this: _____

3. To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NECESSARY: _____

COMMENTS: _____

Emergency Health Practitioner Contact Information

Name of Health Practitioner: _____

Health Practitioner's Phone Number: _____