Emergency Student Information

Name of Student:_____

Date of Birth:_____

Home Address:_____

Parent's Names:_____ #_____

_____#_____

Emergency Contacts:_____#_____

_____#_____

Allergies:_____Medication:_____

_____Medication:_____

_____Medication:_____

_____Medication:_____

As the parent or authorized representative, I hereby give consent to *Odyssey Montessori* to obtain all emergency medical or dental care prescribed by a duly licensed physical (M.D.) osteopath (D.O) or dentist (D.D.S) for _____.
(name of child)

This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of the child named above.

_____ Date:_____
Parent Signature

_____ Date:_____
Parent Signature