MONTESSORI DAY SCHOOL OF BROOKLYN

237 Park Place
Brooklyn, NY 11238

Authorization Form
Emergency Contacts & Pick-Up

Date of Admission ___/___/___

Child's Name (Last) (First) (Middle)	**Gender** F ☐ M ☐	**Date of Birth** Country/State of Birth
Address (No.) (Street) (City/Boro)		

EMERGENCY CONTACTS

Parent #1 Name (address, if different) (Last) (First)	**Telephone No.** Home: Work: Cell:
Parent #2 Name (address, if different) (Last) (First)	**Telephone No.** Home: Work: Cell:
Contact #3	**Relationship To Child**
Address	
Telephone # **Home:** **Work:** **Cell:**	

NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL

Name	**Contact Person**	**Patient No.**
Address		**Telephone #**

SIGNIFICANT HEALTH HISTORY

Medications Taken
Allergies (Medications, Foods, Insect Bites, or Other – Specify)
Appliances Worn (Glasses, etc.)
Conditions Which Modify Activity (Seizures, Anemia, Heart Conditions, etc.)
Has child ever been hospitalized or operated on?
Has child ever had a serious accident (broken bones, head injury, falls, burns, poisoning)?
Has child ever had a serious illness?

I, _____ hereby certify that information provided herein is complete and accurate.

(turn over)

AUTHORIZED PICK-UPS (Min. 3)	
Name #1	**Relationship To Child**
Address	
Telephone # **Home:** **Work:** **Cell:**	
Name #2	**Relationship To Child**
Address	
Telephone # **Home:** **Work:** **Cell:**	
Name #3	**Relationship To Child**
Address	
Telephone # **Home:** **Work:** **Cell:**	
Name #4	**Relationship To Child**
Address	
Telephone # **Home:** **Work:** **Cell:**	
Name #5	**Relationship To Child**
Address	
Telephone # **Home:** **Work:** **Cell:**	
Name #6	**Relationship To Child**
Address	
Telephone # **Home:** **Work:** **Cell:**	