

Amber Meadows Montessori

STUDENT INFORMATION

PARENTS ARE TO COMPLETE THIS FORM

Child's name _____ Gender M F Other _____

Date of birth _____ Date admitted _____

(MM /DD /YYYY)

Parent/ Guardian name _____ Parent/ Guardian name _____

Address: Home _____ City _____ Zip Code _____

Phone No. Home _____ Primary cell M /D _____ Secondary cell M/D _____

Names & ages of children in the family _____

Medical Information

Hospital preference (For emergencies) _____

Children physician _____ phone number _____

Does your child have any of the following problems? If so, please explain _____

- A. Allergies Y N _____
- B. Frequent sore throat / Cold Y N _____
- C. Earache Y N _____
- D. Skin Problems Y N _____
- E. Dietary needs non Veg Veg Special Instruction _____
- F. Other _____

List of any childhood diseases or other illnesses your child has had _____

Have there been any major changes at home that might affect your child in care? Y N

Is there any special information that would help the person caring for your child? Y N

I give permission to the school provider to administer nonprescription meds, such as Acetaminophen, Tylenol, Cough syrup, Cough drops or Ointments Y N explain _____

** Please attach a copy of their current immunization record to this form.