Medical and Emergency Release Form

Child's Name:_____
Birthdate_____ Physical Address:_____
Mailing Adress:_____
Mother's Name:_____Father's Name: _____
Home Phone: _____ Home Phone: _____
Cell Phone: _____ Cell Phone: _____
Work Phone: _____ Work Phone: _____
E-Mail: _____ E-Mail: _____

Name, Address and Phone of Child's Doctor:

_____

Name, Address and Phone of Child's Dentist:

_____

Name, Age and Phone Numbers of All Persons Designated by Parents Whom the Child May be Released and/or Contacted in Case of Emergency:

_____
_____
_____
_____

Person's Not Allowed to Pick Up my Child:

_____
_____
_____
_____

Please describe any Special Medical or Dietary Information below. This should include allergies, medications, special conditions, special disabilities or any additional information on special needs of your child. You may also include any additional information you feel is important for the staff at Morningstar Learning Center to know in order to provide him/her with the best possible care.

_____
_____
_____
_____
_____

I hereby give written consent, indicated by my initials, for the following items below:

_____ Emergency Medical Care, including ambulance transportation if needed.

_____ Administration of Fever Reducing Medication (according to the child's height/weight) only to be given when a child has a fever over 100 degrees and parent(s) cannot be reached.

_____ Supervised walks to and from Westfork Park.

_____ Supervised transportation on the Skyline Bus to The Big Sky Community Park.
_____ Photos to be taken of my child which may be used for advertising purposes, documentation of child's progression, presentations, etc.

In the event of an emergency, I give permission to Morningstar Learning Center's Staff to provide any first aid deemed necessary for my child. If I cannot be reached, the physician listed and the local medical clinic are hereby authorized to provide any emergency care deemed necessary for my child. I understand that my child will be taken to Bozeman Deaconess Hospital by ambulance, at my expense, if medical personnel deem it necessary. In addition, I hereby authorize the transfer of my child's health record to the local hospital or medical clinic if necessary.

_____ _____

Parent's Printed Name Parent's Signature