

**MEDICAL AND EMERGENCY INFORMATION**

**2009-2010 SCHOOL YEAR**

**MONTECITO PRESCHOOL**

**1468 GRANT RD., LOS ALTOS, CA 94024**

**MAIN PHONE: (650) 968-5957; FAX: (650) 968-2052**

**EMAIL: [admin@montecitopreschool.com](mailto:admin@montecitopreschool.com); WEBSITE: [www.montecitopreschool.com](http://www.montecitopreschool.com)**

CHILD'S/ENROLLEE'S FULL NAME: \_\_\_\_\_

CHILD'S CLASS: \_\_\_\_\_

**EMERGENCY & MEDICAL INFORMATION:**

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE(S): \_\_\_\_\_

DENTIST'S NAME: \_\_\_\_\_ PHONE(S): \_\_\_\_\_

As the parent, agency representative or legal guardian, I hereby give consent to Montecito Preschool to provide all emergency dental or medical care prescribed by a duly licensed physician or dentist for \_\_\_\_\_ (child's name). This care may be given under whatever conditions are necessary to preserve the life, limb or well being of dependent/Enrollee/child.

SIGNATURE: \_\_\_\_\_

**CHILD'S/ENROLLEE'S ALLERGIES (IF APPLICABLE):**

Food(s): \_\_\_\_\_

Other Allergies: \_\_\_\_\_

**SEVERITY:** Mild? \_\_\_\_\_ Severe? \_\_\_\_\_ Life Threatening? \_\_\_\_\_

*Please describe on the Teacher Information Sheet what a typical allergic reaction has been in the past and discuss allergies with your child's teachers.*

Does the child require medication to be with him/her? Y \_\_\_\_\_ N \_\_\_\_\_

*If yes, please see the Office for Medication Release Form & Allergy Action Plan to be completed by you and your child's physician & returned to School with the medication.*

**EMERGENCY CONTACT & PICK-UP INFORMATION:**

Please list four (4) local contacts/people who may be contacted in case of an emergency AND the name(s) of person(s), other than parent(s) or guardian(s) listed above, authorized to pick up child/Enrollee from Montecito Preschool. Children WILL NOT be allowed to leave with any other person without written authorization from parent or guardian.

NAME:	CITY:	PHONE(s):	RELATIONSHIP:
1.			
2.			
3.			
4.			