

# OLD MISSION MONTESSORI SCHOOL

4070 Mission Ave.  
Oceanside, CA 92057

Rm. \_\_\_\_\_

## IDENTIFICATION AND EMERGENCY INFORMATION 2009 - 2010

CHILD'S LAST NAME	MIDDLE INITIAL	FIRST	SEX	BIRTHDATE
ADDRESS	NUMBER	CITY	STATE	ZIP
HOME PHONE				
FATHER'S LAST NAME	MI	FIRST	SOCIAL SECURITY #	
BUSINESS PHONE				
HOME ADDRESS	NUMBER	CITY	STATE	ZIP
FATHER'S CELL OR PAGER				
MOTHER'S LAST NAME	MI	FIRST	SOCIAL SECURITY #	
BUSINESS PHONE				
HOME ADDRESS	NUMBER	CITY	STATE	ZIP
MOTHER'S CELL OR PAGER				
PERSON RESPONSIBLE FOR CHILD	LAST NAME	MI	FIRST	HOME PHONE
BUSINESS PHONE				
FATHER'S E-MAIL ADDRESS:				
MOTHER'S E-MAIL ADDRESS:				

### ADDITIONAL PERSONS WHO MAY BE CALLED IN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

### PHYSICIAN OR DENTIST TO BE CALLED IN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE
IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?			
<input type="checkbox"/> CALL EMERGENCY HOSPITAL <input type="checkbox"/> OTHER            EXPLAIN: _____			
PLEASE LIST ANY ALLERGIES OR SPECIAL MEDICAL CONDITIONS THAT YOUR CHILD MAY HAVE:			

### NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR GUARDIAN)

NAME	RELATIONSHIP	NAME	RELATIONSHIP

**AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO OLD MISSION MONTESSORI SCHOOL TO PROVIDE ALL EMERGENCY DENTAL OR MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (MD) OR DENTIST (DDS) FOR MY CHILD. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB, OR WELL BEING OF MY DEPENDENT.**

DATE \_\_\_\_\_ PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

#### TO BE COMPLETED BY OFFICE

RECEIVED COPY OF BAPTISMAL CERTIFICATE	RECEIVED COPY OF FIRST COMMUNION CERTIFICATE
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