

# Maria Montessori Charter Academy Preschool

Pupil's Legal Last Name \_\_\_\_\_ Pupil's First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ PS \_\_\_\_\_  
 \_\_\_\_\_ Male/Female  
 Nickname \_\_\_\_\_ Middle Name \_\_\_\_\_ Other Last Name Used \_\_\_\_\_ Birth Place (City) \_\_\_\_\_ (State) \_\_\_\_\_

Mailing Address: Street, Apt# or PO Box \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Residence Address: \_\_\_\_\_  
 (If Different From Above) Street, Apt# or PO Box \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Not Applicable  
 District of Residence \_\_\_\_\_

Duplicate Mailing: Yes [ ] No [ ] Name: \_\_\_\_\_ Address: \_\_\_\_\_

Parent/Guardian (Full Name)	Name of Employer	Occupation	Work Phone	Street, Apt# or PO Box	City	Zip
Father:				Work/Home E-Mail Address	Living With Student?	
Mother:					Yes [ ] No [ ]	
Step Parent:					Yes [ ] No [ ]	
Guardian:					Yes [ ] No [ ]	

\*Legal Restrictions (A current signed court order must be provided): \_\_\_\_\_  
 \*Court Order on file at school? Yes [ ] No [ ]

Name of Siblings	Brother	Sister	Year Born	School Currently Attending	Adults Other Than Parents Living in Home	Relationship to Student

If the school cannot contact you in an emergency, please name a local sitter, friend or neighbor who may be called if your child is ill or injured. Your child will be released only to those people.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Physician's Name: _____ Phone: _____ My child takes the following Medication: _____ Describe any health conditions, restrictions, or medical treatment (food allergies, other) the School should be aware of: _____ _____	Yes [ ] No [ ]  Yes [ ] No [ ]
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I certify under penalty of law, that the above residence address is my primary residence.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

# MARIA MONTESSORI CHARTER ACADEMY PRESCHOOL EMERGENCY CARD

Student's Last Name	First Name	Birth Date	PS Grade	PRESCHOOL Classroom
Mailing Address (Street, City, Zip)				( ) Home Phone Number
Physical Address (if different)			E-Mail Address	

NOTE: If an emergency occurs, the contact phone numbers on this form will be used to contact a parent, guardian or emergency contact. Please list all applicable contact numbers.

Name – Mother / Step Mother / Guardian \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Name – Father / Step Father / Guardian \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Parent(s) or guardian(s) child lives with \_\_\_\_\_

If parents are separated or divorced, to whom has physical custody been granted? \_\_\_\_\_

If my child is ill, has an emergency, or is suspended and I cannot be reached, please call and release my child to (must be over 18 years old and have ID):

Name – Emergency Contact \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Name – Emergency Contact \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Name – Emergency Contact \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Insurance Company \_\_\_\_\_ Insurance ID# \_\_\_\_\_

1. In the event of an emergency, when a parent or guardian is unavailable, I authorize school personnel to make arrangements for my child to receive medical or hospital care, including necessary transportation, in accordance with their best judgment. I authorize the physician named above to undertake such care and treatment as is considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician or surgeon. I agree to pay all costs incurred as a result of the foregoing.
2. I do not choose the above statement and desire the following action in the event of an emergency and I cannot be reached.

## PLEASE CHECK THE FOLLOWING ITEMS IF THEY PERTAIN TO YOUR CHILD

There are no known health problems

### EYES

Wears Glasses  To be worn at all times   
 Wears Contacts  To be worn at all times

Comments: \_\_\_\_\_

### MEDICATION

Currently taking prescribed medication   
 Prescribing physician \_\_\_\_\_  
 Medication \_\_\_\_\_  
 For \_\_\_\_\_  
 Medication needs to be taken at school   
 If any medication (including over-the-counter) needs to be taken at school, the medication must be kept in the office and a medication form must be filled out and kept in the office.

### EARS

Has a hearing problem   
 Has tubes in ear(s)   
 Uses hearing aid   
 Comments: \_\_\_\_\_

### GENERAL HEALTH

Has the following condition(s):

Diabetes  Fainting Spells   
 Epilepsy  Heart Condition   
 Migraines  Asthma   
 Hyperactive (ADHD)

Allergies  (describe) \_\_\_\_\_

Allergic to bee stings  (describe) \_\_\_\_\_

Other  \_\_\_\_\_

Has a life threatening medical condition

Explain \_\_\_\_\_

By signing below, the parent(s)/guardian(s) certify under penalty of perjury that the information given on this form is true and accurate.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_



# Maria Montessori Charter Academy

1850 Wildcat Blvd.  
Rocklin, CA 95765  
(916) 630-1510  
(916) 624-7305 fax  
www.mmcharter.org

## STUDENT HEALTH INVENTORY

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Medical Advisor \_\_\_\_\_ Last Check-up \_\_\_\_\_

Medical Advisor's Address \_\_\_\_\_ Phone \_\_\_\_\_

Check if appropriate:

<input type="checkbox"/> Wears Glasses	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Speech Difficulty
<input type="checkbox"/> Recurring Ear Infections	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Hernia
<input type="checkbox"/> Frequent Urination		

My child has had the following:

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Mumps	<input type="checkbox"/> Severe Crippling Condition
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Measles (10 day)	<input type="checkbox"/> Tonsil/Adenoid Removal
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles (3 day)	<input type="checkbox"/> Poliomyelitis
<input type="checkbox"/> TB Contact	<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Ear Infection	

Allergies (please explain) \_\_\_\_\_

Limiting Physical Condition (please explain) \_\_\_\_\_

Limiting Mental Condition (please explain) \_\_\_\_\_

Special Health Conditions (please explain) \_\_\_\_\_

Additional Comments \_\_\_\_\_