

MONTESSORI SCHOOL OF BEAVERTON  
**Emergency Medical Treatment Form (EMT)**

As a parent or legal guardian of \_\_\_\_\_, **Birthdate** \_\_\_\_\_, I understand that, in the event of a medical emergency for my child, every effort will be made to reach me at the phone numbers listed below. However, if I cannot be reached in a timely manner, I hereby authorize a member of the staff of the Montessori School of Beaverton, 11065 NW Crystal Creek Lane, Portland, OR, to consent to any medical or surgical treatment of the above child that such persons deem advisable. The above authorization is for the **school year beginning 9/1/11 and expiring after 8/31/12.**

	<b>MOTHER</b>	<b>FATHER, if different</b>
<b>Name</b>	_____	_____
<b>Address</b>	_____	_____
<b>City, Zip</b>	_____	_____
<b>Preferred Email</b>	_____	_____
<b>Phone(s): home</b>	_____	_____
Cell or pager (please label)	_____	_____
<b>Employer</b>	_____	_____
<b>Work Phone</b>	_____	_____
<b>Secondary Email</b>	_____	_____

If parents cannot be reached:

**Emergency Contact #1** \_\_\_\_\_ **Phone(s)** \_\_\_\_\_  
Relationship \_\_\_\_\_

**Emergency Contact #2** \_\_\_\_\_ **Phone(s)** \_\_\_\_\_  
Relationship \_\_\_\_\_

**Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_  
**Dentist/Orthodontist** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Health Insurance Co.** \_\_\_\_\_ **ID #** \_\_\_\_\_  
**Membership #** \_\_\_\_\_ **Group #** \_\_\_\_\_

Chronic illness(es) or allergies \_\_\_\_\_

Medications stored in classroom  
Med Name: \_\_\_\_\_ Exp. Date \_\_\_\_\_  
Med Name: \_\_\_\_\_ Exp. Date \_\_\_\_\_

Current Medications \_\_\_\_\_

**Date of last DTP (Required)** \_\_\_\_\_

Other pertinent information \_\_\_\_\_

\_\_\_\_\_ **OR** \_\_\_\_\_

<b>Signature</b> (Mother/Guardian)	<b>Date</b>	<b>Signature</b> (Father/Guardian)	<b>Date</b>
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