MONTESSORI ACADEMY OF CHAMBERSBURG
875 Ragged Edge Rd Chambersburg, PA 17202

HEALTH SERVICES OVERVIEW **Academic School Year: _____**

Child's Programs: Toddler Preschool K-8 ExCEL Grade: _____ Teacher: _____

Student Full Name: _____ Date of Birth: _____ Gender: _____

PARENT/GUARDIAN CONTACT INFORMATION **PARENT/GUARDIAN(S) ARE ALWAYS FIRST CALLS**

Parent/Guardian Name / Relationship / Phone #

1st Call: _____/_____/_____

2nd Call: _____/_____/_____

HEALTH OVERVIEW

Please select health conditions your child may have and / or may require on-going treatment or monitoring for:

Bleeding Disorders/Cooley's Anemia	Cardiovascular Conditions	Sickle Cell Disease
Asthma	Arthritis/Rheumatic Disease	Cystic Fibrosis
Cerebral Palsy	Spina Bifida	Epilepsy/Seizure Disorder
Attention Deficit Disorder /ADHD	Tourette's Syndrome	Allergy: bee, latex, medicines, etc.
Diabetes Type 1	Diabetes Type 2	Food Allergy: Life-Threatening

Has your child had any recent or significant changes that may impact their academic success related to:

Family Home Life	Learning Disability	Behavioral Concerns
Attendance / Absenteeism	Traumatic Event / Death / Loss	New Health Diagnosis / Hospitalization

Comments:_____

_____

PROOF OF HEALTH INSURANCE: Company: _____ Policy #: _____

_____**CONSENT FOR SCREENINGS** I give permission to participate in routine screenings including vision, hearing, language and speech.

EMERGENCY CONTACTS AND AUTHORIZED PICK UP: LOCAL TRUSTED ADULTS WHO MAY CARE FOR CHILD

Emergency Contacts: Name / Relationship / Phone#

CRITICALLY IMPORTANT DURING EMERGENCIES – DO NOT LIST YOURSELVES

Contact #1: _____/_____/_____

Contact #2: _____/_____/_____

Contact #3: _____/_____/_____

Additional Adults Authorized to Pick-up Child from School: Name / Relationship / Phone#

Adult #1: _____/_____/_____

Adult #2: _____/_____/_____

Adult #3: _____/_____/_____

In the event my child becomes ill or injured at school or there is a man-made or natural disaster, and I cannot be reached, Montessori Academy of Chambersburg is authorized to: Release child to specified adults; Provide lifesaving or limb preserving care; Call Emergency Medical Services &/or transport my child to Chambersburg Hospital. I understand that I am responsible for all expenses incurred for emergency care or transportation.

_____Consent to release health information to Emergency Medical Services and Hospital.

_____Consent to release health information to staff/volunteers as necessary to ensure student safety [allergy/conditions].

_____Consent for MAC or CASD staff to provide care / comfort / First Aid for minor health issues or injuries.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____