

# MONTESSORI SCHOOL OF DOUGLAS COUNTY, INC.



P.O. BOX 272  
Douglasville, Georgia 30134  
770-949-3115  
EMERGENCY CONTACT FORM

DATE: \_\_\_/\_\_\_/\_\_\_

CHILD'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_/\_\_\_/\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY STATE ZIP HOME PHONE NUMBER

MOTHER'S NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS (If different from child's): \_\_\_\_\_

MOTHER'S WORKPLACE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS (If different from child's): \_\_\_\_\_

FATHER'S WORKPLACE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

PHYSICIAN'S ADDRESS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

MEDICAL HISTORY: \_\_\_\_\_

PERSON(S) OTHER THAN PARENT THAT CHILD CAN BE RELEASED TO:

1) NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

1) NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

1) NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

1) NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SCHOOL USAGE ONLY: Program Schedule: (HALF DAY) (9AM-3PM) (FULL DAY)

CLASS PLACEMENT: