## CONSENT FOR EMERGENCY TREATMENT/HEALTH POLICY
## 2025-2026 SCHOOL YEAR

**Children will not be permitted at the school with any of the following:**

- Fever of 100.4 degrees F (axillary) or higher; temperature must be normal for a 24-hour period without the use of fever reducing medications before child can attend.
- Cough
- Vomiting/diarrhea within the past 24 hours
- Shortness of breath
- Sore throat
- Congestion or runny nose
- Muscle aches or chills within the past 24 hours
- Unusual fatigue
- New loss of taste or smell

It is the school's expectation that parents be available immediately at any time in case of illness or emergencies involving their child while at school. A parent/guardian or another person authorized by the parent must be available to pick up an ill child within 30 minutes of the school's report of illness.

I hereby give permission for my child ______________________________ to be given emergency treatment by a qualified staff member of Lakeview Montessori. I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

In the event that I cannot be contacted, I further consent to the medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health.

**Parent's Signature** ______________________________ **Date** _______________

**A SEPARATE FORM MUST BE COMPLETED FOR EACH CHILD IN THE FAMILY.**

**Child's Physician** ___________________________ **Phone** _____-______-________ **Address**_________________

**Child's Dentist** ______________________________ **Phone** _____-______-________ **Address**_________________

**Preferred Hospital** ___________________________

**Date of Last Physical or Doctor's visit** ___________________ **(must be within 2 years)**

**Child's Allergies (Food or/medical conditions)** __________________________________________________

**(Parents provide child's snacks when food allergies exist)**

Does your child have?

frequent colds _____
frequent sore throats _____
frequent ear problems _____
problems with skin rash _____
heart trouble _____
convulsions _____
fainting spells _____
diabetes _____
asthma _____
allergies (type of) _____
stomach upsets _____
urinary problem _____
problems w/diarrhea _____
problems w/constipation _____
problems w/soiling _____

Has your child had any of these diseases?

| Disease | | Date |
|---|---|---|
| bronchitis | _____ | ______ |
| ringworm | _____ | ______ |
| impetigo | _____ | ______ |
| head lice | _____ | ______ |
| chicken pox | _____ | ______ |
| hepatitis | _____ | ______ |
| scarlet fever | _____ | ______ |
| tuberculosis | _____ | ______ |
| measles (hard ) | _____ | ______ |
| German measles(3 day) | _____ | ______ |
| mumps | _____ | ______ |
| poliomyelitis | _____ | ______ |
| whooping cough | _____ | ______ |
| worms | _____ | ______ |

Has your child ever been hospitalized? _____________________________________

When was your child's vision and hearing last tested? __________ By whom? _____________________

**Primary Contact** ___________________________ **Daytime phone** _______-_______-___________

**Secondary Contact** ____________________________ **Daytime phone** _______-_______-___________

Other Emergency contact person (available during day to care for your child if you are unavailable)

____________________________________________ Relationship ____________

Phone _______-_______-_________ Address _____________________________________