



## Medical & Emergency Release Form

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Physical Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Email Address \_\_\_\_\_

**Name, Address and Phone of Child's Physician or Source of Medical Care:**

\_\_\_\_\_

**Name, Address and Phone of Child's Dentist:**

\_\_\_\_\_

**Name, Age and Phone Numbers of All Person's Designated by Parents to Whom the Child May be Released and/or Contacted in Case of Emergency:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Person's Not Allowed to Pick Up my Child:**

\_\_\_\_\_

\_\_\_\_\_

**Please complete the back of this form!**

**Please describe any Special Medical or Dietary Information below. This should include allergies, medications, special conditions, special disabilities or any additional information on special needs of your child. You may also include any additional information you feel is important for the staff at Morningstar Learning Center to know in order to provide him/her with the best possible care.**

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**I hereby give written consent, indicated by my initials, for the following items below:**

\_\_\_\_\_ Emergency Medical Care, including ambulance transportation if needed.

\_\_\_\_\_ Administration of Fever Reducing Medication (according to the child's height/weight) only to be given when a child has a fever over 100 degrees and parent(s) cannot be reached.

\_\_\_\_\_ Supervised walks to and from the Big Sky Community Park.

\_\_\_\_\_ Photos to be taken of my child which may be used for advertising purposes, documentation of child's progression, presentations, etc.

**In the event of an emergency, I give permission to Morningstar Learning Center's Staff to provide any first aid care deemed necessary for my child. If I cannot be reached, the physician listed on the other side of this form and the local hospital or medical clinic are hereby authorized to provide any emergency care deemed necessary for my child. I understand that my child will be taken to Bozeman Deaconess Hospital by ambulance, at my expense, if medical personnel deem it necessary. In addition, I hereby authorize the transfer of my child's health record to the local hospital or medical clinic if necessary.**

\_\_\_\_\_  
Parent's Printed Name

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date