Lagniappe Montessori

& Children's Center

Master Card

Child's Name: _____ Sex: _____ DOB: _____

Enrollment Date: _____

	Mother	Father
Name		
Address		
Employer		
Home Phone #		
Work Phone #		
Cell Phone #		
Email Address		

Person with whom the child lives: _____

Child's Doctor: _____ Doctor's Phone # _____

Child's Dentist: _____ Dentists Phone # _____

Persons to call in an emergency if parents are unavailable and persons that my child may be released to: (PLEASE INCLUDE NAME, ADDRESS, PHONE NUMBER, AND RELATIONSHIP.)

1) _____

2) _____

3) _____

4) _____

Does your child have any food or other allergies? If so, please explain.

_____

_____

Does your child have any dietary restrictions? If so, please explain.

_____

_____

My child has permission to be released to the following individuals in addition to the emergency contact persons listed above. (PLEASE NOTIFY THESE INDIVIDUALS THAT THEY MY BE ASKED TO SHOW PROOF OF IDENTITY.)

Name	Relationship

Authorization:

1) Emergency Medical Treatment

I authorize Lagniappe Montessori and Children's Center to secure emergency medical treatment for my child in the event it becomes necessary.

Parent's signature: _____ Date _____

Insurance Information:

_____

_____

2) Press Releases and Website Photos

I give my permission for my child to be interviewed and photographed for school events (For website use or newspaper releases.)

Parent's signature: _____ Date _____