Emergency Information

LePort Montessori

Child's name _____ ❒ Male ❒ Female Birthdate _____

1. Emergency Contact Information

In addition to parent(s) who will be contacted first in case of emergency.

	Name	Relationship to Child	Phone	Authorized Pickup?
1				☐ Yes ☐ No
2				☐ Yes ☐ No
3				☐ Yes ☐ No
4				☐ Yes ☐ No

Is any parent/guardian or other person specifically not authorized for pick-up? ❒ Yes ❒ No

If yes, please list name, relationship to child, and any relevant details. ***If the non-authorized person is a parent, you must provide appropriate legal paperwork.***

Name _____ Relationship to Child _____

2. Persons Authorized to Pick Up–*in addition to parent(s) and emergency contacts listed above*

	Name	Relationship to child/family	Phone
1			
2			
3			
4			
5			
6			

3. Physician and Insurance Information

	Pediatrician or primary care provider	Dentist
Name		
Street address		
City, State, Zip		
Phone		
Insurance company		Policy ID#

Parent name _____ Signature _____ Date _____

Field Trip, Transportation & Medical Release

LePort Montessori

Child's Name _____ Gender _____ Birthdate _____

1. Field Trip Permission and Transportation Release

I/we, the undersigned parent(s) or guardian(s) of _____, a minor, do hereby request that he/she be permitted to attend LePort Montessori field trips and activities scheduled throughout the school year (from the date on this form through August 31, 2027). Said field trips and activities may refer to a range of activities, including but not limited to, the child being taken off campus for walks, hikes, parent-chaperoned going-out trips, and, for infants, buggy rides through the neighborhood.

List any medicines your child requires at school and may need to take with him/her on field trips (to include but not limited to Epi-Pen or Inhaler/Nebulizer). List any medical conditions and developmental issues that must be known on field trips your child takes:

I/we understand that neither LePort Montessori, nor any of its officers, administrators, teachers, staff, or parent chaperones are liable for any accident or injuries that may occur to the above-named student as a result of any aspect of his/her participation in any school-sponsored field trip or activity.

Parent name _____ Signature _____ Date _____

2. Essential Contact and Emergency Information Copied from Other Forms — *This form goes with child on field trip; below essential information needed for safety may be duplicated from other forms.*

	Name	Phone to call in case of an emergency
Parent/Guardian #1		
Parent/Guardian #2		
Pediatrican or primary care provider		
Dentist or orthodontist		

Insurance company _____ Policy ID# _____

My child has food allergies: ❒ Yes ❒ No

If yes, the child's food allergy form, allergy treatment plan, and (if provided) epinephrine auto-injector or other allergy medications must be taken on the field trip *and stay with the child throughout the trip. A food allergy safety adult (child's parent, teacher, or volunteer chaperone) may, at the parent's request, be designated, be trained on the child's allergies and treatments, and stay in the child's field trip group for the entire time of the trip. The child may be asked to wear allergy identification to help keep him/her safe.*

My child does not eat certain foods due to personal or religious beliefs: ❒ Yes ❒ No
If yes, please describe your child's food restrictions and any special dietary requirements:

3. Emergency Medical Release

I/we hereby authorize LePort Montessori personnel to seek medical attention for my child in the event of an emergency. I/we, as parent/guardian(s) also authorize LePort Montessori personnel to transport my child to the appropriate medical facility in the event that urgent/emergency medical care is necessary, or to call 911. The hospital and its medical staff have my authorization to provide any treatment which a physician deems necessary for the well-being of my child. It is understood that every effort shall be made to contact me/us prior to rendering treatment to my child, but that necessary treatments will not be withheld if I/we cannot be reached. I will not hold liable LePort Montessori, its officers, staff, or volunteer parents for medical aid rendered during a field trip, at school, or at the hospital/medical provider office, and will reimburse LePort Montessori for medical or other expenses incurred in the care of my child. This authorization is given pursuant to Section 6910 of the Civil Code of California and remains in effect from the date of this form through August 31st, 2027.

Parent name _____ Signature _____ Date _____

Nutrition and Allergy Information

LePort Montessori

Child's Name _____ Gender _____ Birthdate _____

1. Nutrition Preferences, Restrictions & Food/Environmental Allergies–*complete for every child*

My child does not eat certain foods due to personal or religious beliefs: ❒ Yes ❒ No
If yes, please describe your child's food restrictions and any special dietary requirements below:

My child has food and/or environmental allergies: ❒ Yes ❒ No
If yes, you must complete the food/environmental allergy information (Section 2) below. If your child acquires a new food or environmental allergy, you must notify us immediately and provide an updated version of this form.

2. Allergy Information— *complete for every child with allergies (dietary and/or environmental)*

In response to eating one of his/her food allergens or being exposed to his/her environmental allergen, has your child ever experienced one of the following:	Yes	No
He/she has had a systemic allergic reaction (e.g., hives over larger parts of his/her body, severe stomach pains, nausea or vomiting, breathing problems).	❒	❒
He/she has needed medical attention during an allergic incident (e.g., has been taken to the pediatrician's or allergist's office, taken to urgent care or an ER, called 911, or had injectable epinephrine administered).	❒	❒
He/she has been prescribed an epinephrine auto-injector (EpiPen, AuviQ, or similar).	❒	❒

If you answered yes to any of the above questions, to enroll your child at LePort Montessori, you will need to either (1) provide an epinephrine auto-injector for us to keep at school, or (2) provide a written notice from your child's physician that an epinephrine auto-injector is not required for your child to be safe. You will also need to provide a written, detailed treatment plan provided or approved by your physician, for our staff to follow in case of an allergic reaction.

Food or Environmental Allergen *--e.g. peanuts, walnuts, egg, dairy, etc. or grass, pollen, dander, etc.*	Description of Severity of Allergy, Expected Symptoms & Treatment— *e.g., anaphylactic/life-threatening (may lead to vomiting, breathing problems…), or mild (hives, itching); and if Benadryl, inhaler/ nebulizer or any other medication should be used as treatment*	Epi for Treatment? *Epinephrine required to treat this allergen?* Yes	No
		❒	❒
		❒	❒
		❒	❒
		❒	❒

❒ Check here if 1) your child has more than four food or environmental allergies so we may discuss in person and prepare an addendum to this form; or 2) regardless of the number of your child's food/environmental allergies, you would like to discuss in person so we may better understand your child's needs with respect to allergies.

3. Allergy Medication & Topical Products Consent and Administration Authorization— *complete for every child.*

This medication should be provided to my child as needed from the date of this form through August 31, 2027. I authorize LePort Montessori to administer the above prescription(s) and/or over-the-counter medication to my child as indicated above. I further authorize LePort Montessori to administer any and all topical products to include but are not limited to: Sunscreen, diaper cream, chapstick and lotion. I understand that it is my responsibility to provide LePort Montessori with any and all medications and topical products, and full treatment plan, as necessary to treat my child's allergies and/or medical condition. It is also my responsibility to verify the expiration date(s) of any medications supplied to the school and make note of the date(s) to provide the school with replacement medications. I will inform LePort Montessori if I become aware that my child is allergic to any food(s) and/or if my child is no longer allergic to an item. I understand that all prescription or over-the-counter medications and topical products must be provided in the original packaging with appropriate labels affixed. In addition, if I have provided an epinephrine auto-injector to LePort Montessori for my child, I must also provide a case that will maintain a proper temperature for the device, when stored indoors and carried outdoors.

Parent Name _____ Signature _____ Date _____

For School Office Use Only

- ❒ ProCare
- ❒ Allergy list (classroom, office, emergency backpack & snack cupboard)
- ❒ HOS informed
- ❒ Meeting not required
- ❒ Meeting required & scheduled: Date _____ Time_____
- ❒ Allergy info & meeting notes provided to Head Teacher/Homeroom Teacher

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street	City	ZIP code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	_____/_____/_____
Physical Examination	_____/_____/_____
Dental Assessment	_____/_____/_____
Nutritional Assessment	_____/_____/_____
Developmental Assessment	_____/_____/_____
Vision Screening	_____/_____/_____
Audiometric (hearing) Screening	_____/_____/_____
TB Risk Assessment and Test, if indicated	_____/_____/_____
Blood Test (for anemia)	_____/_____/_____
Urine Test	_____/_____/_____
Blood Lead Test	_____/_____/_____
Other	_____/_____/_____

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER (e.g., TB Test, if indicated)					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER *(optional)* *and* RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

☐ Examination shows no condition of concern to school program activities.

☐ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

☐ Please check this box if you ***do not*** want the health examiner to fill out Part III.

Signature of parent or guardian — Date

Name, address, and telephone number of health examiner

Signature of health examiner — Date

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

INFORME DEL EXAMEN DE SALUD PARA EL INGRESO A LA ESCUELA

Para proteger la salud de los niños, la ley de California exige que antes de ingresar a la escuela todos los niños tengan un examen médico de salud. Por favor, pidale al examinador de salud que llene este informe y entregelo a la escuela—este informe sera archivado por la escuela en forma confidencial.

PARTE I PARA SER LLENADO POR EL PADRE/LA MADRE O EL GUARDIÁN

NOMBRE DEL NIÑO/NIÑA—Apellido	Primer Nombre	Segundo Nombre	FECHA DE NACIMIENTO—Mes/Día/Año

DOMICILIO—Número y Calle	Ciudad	Zona Postal	Escuela

PARTE II PARA SER LLENADO POR EL EXAMINADOR DE SALUD

EXAMEN DE SALUD

AVISO: Todas las pruebas y evaluaciones excepto el análisis de sangre para el plomo deben ser hechas después de la edad de 4 años y 3 meses.

PRUEBAS Y EVALUACIONES REQUERIDAS	FECHA(mm/dd/aa)
Historia de Salud	_____/_____/_____
Examen Físico	_____/_____/_____
Evaluación de Dientes	_____/_____/_____
Evaluación de Nutrición	_____/_____/_____
Evaluación del Desarrollo	_____/_____/_____
Pruebas Visuales	_____/_____/_____
Pruebas con Audiómetro (auditivas)	_____/_____/_____
Evaluacion de Riesgo y prueba Tuberculosis*	_____/_____/_____
Análisis de Sangre (para anemia)	_____/_____/_____
Análisis de Orina	_____/_____/_____
Análisis de Sangre para el plomo	_____/_____/_____
Otra	_____/_____/_____

REGISTRO DE INMUNIZACIONES

Aviso al Examinador: Por favor dé a la familia, una vez completado, o a la fecha, el Registro de Inmunización de California en papel amarillo.
Aviso a la Escuela: Por favor apunte las fechas de inmunización sobre el Registro de Inmunización de la escuela de California en papel azul.

VACUNA	FECHA EN QUE CADA DOSIS FUE DADA				
	Primero	Segundo	Tercero	Quarto	Quinto
POLIO (OPV o IPV)					
DTaP/DTP/DT/Td (difteria, tétano y [acellular] pertusis [tos ferina]) O (tétano y difteria solamente)					
MMR (sarampión, paperas, rubéola)					
HIB MENINGITIS (Hemófilo, Tipo B) (Requerida para centros de cuidado para niños y centros preescolares solamente)					
HEPATITIS B					
VARICELLA (Viruelas locas)					
OTRA (e.g. prueba TB, de ser indicado)					
OTRA					

PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD *(optional)*

RESULTADOS Y RECOMENDACIONES

Llene esta parte si el padre/la madre o el guardián ha firmado el consentimiento para divulgar (distribuir) la información de salud de su niño/niña.

☐ El examen reveló que no hay condiciones que conciernen las actividades de los programas escolares.

☐ Las condiciones encontradas en el examen o después de una evaluación posterior que son de importancia para la actividad escolar o física son: (por favor explique)

***de ser indicado**

y PERMISO PARA DIVULGAR (DISTRIBUIR) EL INFORME DE SALUD

Yo le doy permiso al examinador de salud para que comparta con la escuela la información adicional de este examen como es explicado en la Parte III.

☐ Por favor marque esta caja si Ud. no desea que el examinador llene la Parte III.

Firma del padre/madre o guardián _____ Fecha _____

Firma del examinador de salud _____ Fecha _____

Si su niño o niña no puede obtener el examen de salud llame al Programa de Salud para la Prevención de Incapacidades de Niños y Jovenes (Child Health and Disability Prevention Program) en su departamento de salud local. Si Ud. no desea que su niño(a) tenga un examen de salud, puede firmar la orden (PM 171 B), formulario que se consigue en la escuela de su niño(a).
CHDP website: www.dhcs.ca.gov/services/chdp

Modification Request Form

STUDENT NAME: _____ **GRADE:** _____ **DATE OF BIRTH:** _____

Would your child need assistance and/or modifications in order to fully participate in this school's programs and services?

Check one: ☐ **No** (Please skip the Request section below, and sign/date the bottom of this form)

☐ **Yes** (Complete the rest of this form, sign and submit the form with supporting documents, if any)

You may change your election on this form at any time, by providing written requests to Principal or Assistant Principal.

Request – to be completed by Family

If you responded Yes above, please describe any requests for modifications to our school's programs and services.

Describe the reason for each requested modification:

Requested Modifications to School Policies or Programs:

☐ **Use a separate sheet of paper, if you need more space**

Please provide any supporting documents to help the school understand the student's abilities, needs, and any current or pending support services for the student, including but not limited to:

- ☐ Documents from the student's health care providers
- ☐ Documents from a therapist or a public school district that evaluated the student (e.g. IEP)
- ☐ Others: _____

We only need information relevant to the requested modifications.

_____ _____ _____

Parent/Guardian Printed Name **Parent/Guardian Signature** **Date**

To Be Completed by School					
School Name		School Number		Principal	
Date Received		Person Received			