



## EMERGENCY CONTACT

THE BEMENT SCHOOL  
94 OLD MAIN STREET  
PO BOX 8  
DEERFIELD, MA 01342  
Phone: 413-475-3044  
Fax: 413-774-7863

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
Last First Nickname

Address \_\_\_\_\_ Primary Phone \_\_\_\_\_  
Street & Number City State Zip

Parent/Guardian \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work \_\_\_\_\_

### Emergency Contacts:

1. \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

2. \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Allergies or Dietary Restrictions: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Information: \_\_\_\_\_  
Company Policy #

My child has permission to engage in all program activities and Bement sanctioned trips.

Authorization for Treatment: In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to secure and administer treatment, including hospitalization at the nearest facility for the above named person. This form may be photocopied for trips off campus.

Authorization for Photo Release: I hereby give my permission to allow photographs of my child to used by the Bement School for print or electronic publications (promotional literature, web site, brochure, etc.)

Yes \_\_\_\_\_ No \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_