



Temple Beth Sholom

Salem Jewish Congregation...Honoring Our Past by Building a Vibrant Future

Emergency Information

Student name _____ List any long-term medications _____ _____ Dosage _____ Condition _____ Will it be taken at school? Y ___ N ___ Manner administered _____ Can child administer? Y ___ N ___ If no, who can? _____ Other health information: ___no known health problems ___asthma ___epilepsy ___hearing problems ___vision problems ___allergies ___heart condition foods _____ medications _____ bee stings _____ treatment needed _____ ___ ADD / ADHD _____ ___ other (please specify) _____ _____ ___ any significant life changes or disruptions about which we should be aware _____ _____ ___ any learning issues _____ _____ _____	Student name _____ List any long-term medications _____ _____ Dosage _____ Condition _____ Will it be taken at school? Y ___ N ___ Manner administered _____ Can child administer? Y ___ N ___ If no, who can? _____ Other health information: ___no known health problems ___asthma ___epilepsy ___hearing problems ___vision problems ___allergies ___heart condition foods _____ medications _____ bee stings _____ treatment needed _____ ___ ADD / ADHD _____ ___ other (please specify) _____ _____ ___ any significant life changes or disruptions about which we should be aware _____ _____ ___ any learning issues _____ _____ _____
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If my child is ill or has an emergency and I cannot be reached, please call and release my child in order of preference to:

Name _____	Phone _____
Relationship _____	Cell phone _____
Name _____	Phone _____
Relationship _____	Cell phone _____

In case of an accident or sudden illness, when a parent or guardian is unavailable, I authorize a Temple Beth Sholom representative to obtain medical care for my child, including necessary transportation, in accordance with their best judgment. I further authorize the doctor named below to provide the care and treatment he/she considers necessary. If the physician designated below is unavailable, I authorize such care and treatment to be performed by a licensed physician selected by the synagogue representative. I agree to pay all costs incurred as a result of the foregoing.

Medical insurance plan _____ Group # _____
 Medical/patient id number(s) _____
 Doctor name _____ Phone _____
 Dentist name _____ Phone _____

Parent name (print)

Parent signature