

**CONGREGATION BETH AM**  
**EMERGENCY CONTACT INFORMATION / RELEASE FORM**  
**5770 ☆ 2009-2010**

**One form per student**

*Please Print Clearly!*

**Student's Last name:** \_\_\_\_\_ **First name:** \_\_\_\_\_ **Middle name:** \_\_\_\_\_

Hebrew name: \_\_\_\_\_ Gender: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Student's address: \_\_\_\_\_

Student's Email address: \_\_\_\_\_ Student's Cellular telephone: \_\_\_\_\_

Grade in secular/day school: \_\_\_\_\_ Name of school: \_\_\_\_\_

Child resides with:  Mother  Father  Both  Other: \_\_\_\_\_

(If child lives with someone other than a parent, please give complete contact information on a separate sheet of paper and attach it to this page before mailing.)

**Parents' Information**

Parent 1's name: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Telephone numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Pager/Cellular telephone: \_\_\_\_\_ Other: \_\_\_\_\_

Address if different from student's: \_\_\_\_\_

Parent 2's name: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Telephone numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Pager/Cellular telephone: \_\_\_\_\_ Other: \_\_\_\_\_

Address if different from student's: \_\_\_\_\_

**Medical Information**

Physician name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Insurance company: \_\_\_\_\_ Plan/Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Emergency Contact Information**

Should my child become ill and a parent cannot be reached, please notify either of the following people:

(1) Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

OK to pick up:  Y  N

(2) Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

OK to pick up:  Y  N

Also, should a civil defense emergency or natural disaster such as an earthquake occur, and I am unable to reach Congregation Beth Am to pick up my child, by checking the appropriate box(es) above, I designate the above person(s) to pick up my child.

**Medical Information, cont.**

Drug Allergies: \_\_\_\_\_

Does your child/family have a history of any of the following: (Please check any that apply.)

- Severe bee sting reaction                       Asthma                       Seizure disorder \_\_\_\_\_
- Diabetes       Sight problems       Hearing difficulties       Heart condition \_\_\_\_\_
- Allergies \_\_\_\_\_  Other (Please explain). \_\_\_\_\_
- Specific food allergies (please specify): \_\_\_\_\_

Is your child presently taking medication on a continuing basis?  Y  N If yes:

Name of medication: \_\_\_\_\_ Current dosage & schedule: \_\_\_\_\_

Prescribed for what condition: \_\_\_\_\_

Name of medication: \_\_\_\_\_ Current dosage & schedule: \_\_\_\_\_

Prescribed for what condition: \_\_\_\_\_

Name of medication: \_\_\_\_\_ Current dosage & schedule: \_\_\_\_\_

Prescribed for what condition: \_\_\_\_\_

What else should we know about your child to be able to help her/him effectively in the unlikely event of an injury or accident? \_\_\_\_\_

**Please read the following carefully and then sign in the boxes below.  
We cannot accept your registration without your signatures below.**

**Permission to Seek Treatment**

In the case of injury to, or illness of, a child while at Congregation Beth Am or on a retreat or other off-site activity, every effort will be made to contact the parent(s) or guardian. If a representative of Beth Am is unable to reach such person, the following instruction will remain in force unless revoked by the parent or guardian:

I hereby authorize Congregation Beth Am or any authorized representative to call my child's physician or dentist (or another physician or dentist available) for necessary care for my child in case of emergency. I agree to pay all expenses incurred. These authorizations shall remain effective from September 1, 2008 to June 30, 2009.

In addition, I do hereby authorize a representative(s) of Congregation Beth Am as agent (s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnoses or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician or surgeon licensed under the provisions of the California Medical Practice Act, whether such examination, diagnoses or treatment is rendered at the office of said physician or at a government licensed hospital.

It is understood that this authorization is given in advance of any specific examination, diagnosis, treatment, or hospital care being required, and is given to provide authority and power on any and all such examinations, diagnoses, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of California Family Code 6910.

**\*Parent's signature:** \_\_\_\_\_ **\*Date:** \_\_\_\_\_

I understand that when any of the above information changes, I should contact the Beth Am Education Office as soon as possible at (650) 493-4665 or youthed@betham.org.

**\*Parent's signature:** \_\_\_\_\_ **\*Date:** \_\_\_\_\_