MADRICHIM

CONGREGATION BETH AM

EMERGENCY CONTACT INFORMATION / RELEASE FORM

One form per student

Student's Last name: _____ **First name**:_____ **Middle name:** _____

Hebrew name: _____Gender: _____ Birth date: _____Age: _____

Student's address: _____

Student's Email address: _____Student's Cell Phone: _____

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/Cell Phone:_____ Other: _____

Address if different from student's: _____

Parent 2's name: _____ E-mail address: _____

Telephone numbers: Home: _____ Work: _____

Pager/Cell Phone:_____ 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.

continued on reverse ➲

Medical Information, cont.

Drug Allergies: _____

Does your child have a history of any medical issues, such as asthma, diabetes, allergies, hearing difficulties, etc? Please specify: _____

_____

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

Name of medication(s): _____

Prescribed for what condition(s): _____

Does your child carry any medication with him/her? ☐ Y ☐ N

If yes, which medications? What is his/her medication schedule?

Are there any medications or medical supplies that we should store for your child in the Education Office?

☐ Y ☐ N If yes, which medications or supplies? Please list medications and the situations in which they should be used. Medications should be hand delivered to the Youth Education Office. All medications or supplies must be clearly labeled with your name, your telephone number(s), your child's name, and a picture of your child.

_____

_____

_____

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 June 1, 2015 to June 30, 2016.

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 signature: _____ **Date:** _____