

TEMPLE BETH SHALOM

MORRISON BIAL CENTER FOR JEWISH EDUCATION

RELIGIOUS SCHOOL MEDICAL RELEASE/EMERGENCY FORM

*I, _____, hereby give my consent to the Administrator, or persons designated by the Temple Beth Shalom Religious School, to make available to my child, _____, any and all emergency professional care as deemed necessary should an emergency arise. It is further understood that a conscientious effort will be made to notify me, my spouse, or guardian before such action is taken. It is further understood that every effort will be made to contact my child's physician prior to any treatment. In the event a contact is not reached, or it is not possible for one to be reached in time, I give my permission for him/her to receive proper medical attention by any doctor, nurse, paramedic or member of a medical staff of a hospital licensed by the State of Florida. I certify that my child is in good physical and emotional health, and that he/she has my permission to participate in all Religious School activities that are part of the regular program and supervision of designated persons.

Any physical limitations, medications, special dietary needs, allergies, and other indications, are stated on this form.

Child's Name _____ Physician _____ Phone Number: _____

Please List Any Special Needs: _____

Mother's Name: _____ Phone Number: _____

Father's Name: _____ Phone Number: _____

Guardian's Name: _____ Phone Number: _____

Child Resides with: Mother ___ Father ___ Both ___ Other _____

Emergency Contact: _____ Address: _____

Phone Number: _____ Cell Phone: _____ Relationship to Child: _____

THE FOLLOWING PEOPLE CAN PICK UP MY CHILD:

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

INSURANCE INFORMATION:

Insurance Company: _____ Customer Service Phone Number: _____

Primary Insured: _____ Policy #: _____ Group #: _____

Child's Physician: _____ Phone Number: _____

Dental Insurance Company: _____ Customer Service Phone Number: _____

Primary Insured: _____ Policy #: _____ Group #: _____

Child's Dentist: _____ Phone Number: _____

Hospital: _____ Phone Number: _____ Child's Blood Type: _____

Date: _____ Parent Signature: _____