

Medical Information

Please inform us of any allergies and/or medical conditions that may impact your child during school hours:

Medications:

Doctor (Name & Phone) _____

May we contact Doctor if necessary? Y N

In the event of an emergency, do you give us your permission to call an ambulance? Y N

Emergency Contact #1 _____ Phone # _____

Emergency Contact #2 _____ Phone # _____

General Learning Profile

Please note that confidentiality will be respected at all times!

Does your child have any type of special learning need? Y N

Does he/she receive any special services for secular school, such as special education classes, resource room pull-out program, or other services? If so, please explain.

Is there anything else you would like us to know about your child (subjects that he/she particularly likes or dislikes, special interests or hobbies, areas of strength or weakness, significant changes in school or at home that your child has experiences in the past year, etc.)?

This health history is correct to the best of my knowledge and the student herein described has permission to engage in all activities. I give permission to the physician or hospital selected by a representative of Temple Beth Shalom Religious School to hospitalize, secure emergency treatment in case of an accident, or provide routine treatment for common conditions such as colds, infections and minor injuries. This authorization does not cover elective surgery or elective hospital treatment.

Signature of Parent/Guardian _____ Date _____

Health Insurance Company _____ Policy # _____