BETH TORAH
SCHECK FAMILY
RELIGIOUS SCHOOL

EMERGENCY HEALTH FORM 2021 - 2022

(Personal and Confidential for Health Office only - PLEASE PRINT)

Student's Name: _____ Date of Birth: _____ Grade: _____ Sex: M F
First and Last Name

Address: _____ Apt. #:_____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ E-mail address: _____

Mother's Name: _____Cell Phone #: _____
Employer: _____Work Phone #: _____

Father's Name: _____ Cell Phone#: _____
Employer: _____ Work Phone #: _____

Guardian's Name: _____ Cell Phone #: _____
Employer: _____ Work Phone #: _____

EMERGENCY CONTACTS (other than parents)

Primary Emergency Contact	Secondary Emergency Contact
Name: _____	Name: _____
Home Phone #: _____	Home Phone #: _____
Cell Phone #:_____	Cell Phone #: _____
Work Phone #: _____	Work Phone #: _____

MEDICAL INFORMATION

1. **Allergy(ies):** _____
2. **Daily Medication(s) – please list all medications even if not given in school:**_____
   _____
3. **Describe medical conditions for which your child receives treatment (anemia, asthma, diabetes, headaches, orthopedic, epilepsy, digestive, cardiac, allergies, etc.):**_____
   _____
4. **Does your child have any restrictions on his/her activities? ____Yes ____No**
   If yes, please explain: _____
5. **Does your child have any health needs which require nursing during school hours? ___Yes ___No**

   ***If yes, please specify:** _____
   *** Please contact the school nurse if the answer is yes to set up a health care plan.**
6. **List any additional information that you would like the school/nurse to know about your child:**_____

   _____

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The health services at the Scheck Family Religious School are designed to provide immediate first aid, administer medication, and provide short-term care to students (until a parent or designated Emergency Contact can pick up the student). A diagnosis cannot be made, nor are there facilities for extended periods of bed rest. Parents need to pick up their children within one hour of being called by the nurse. We ask for your cooperation by keeping your child home if there is any question of illness.

Primary Doctor's Name: _____ Phone #: _____

Dentist's Name: _____Phone #: _____

Hospital/Clinic Preference _____ Phone #: _____

In case of an emergency, do you authorize the use of the nearest hospital, other than the one listed above?

☐ **YES** ☐ **NO**

****In the case of an emergency during field trips, the nearest hospital will be used.**

I, the undersigned, hereby consent to and authorize the nearest hospital or health clinic and its physicians in charge of my child's care, to perform emergency treatments or diagnostic procedures including all medical and surgical treatment, x-ray, laboratory, anesthesia and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Insurance Co: _____

Policy #: _____ Group #: _____

Ins. Telephone #: _____

Student's Name: _____

Parent/Guardian Names: _____

Parent/Guardian Signature: _____Date: _____