



Dear Families:

Welcome to J2M / Beth Torah Benny Rok Campus B'nai Mitzvah Experience for the 2022-2023 school year. We are so happy you have chosen our school and we are excited for the journey ahead!

As we prepare for the upcoming journey, please complete and submit electronically the Back to journey package. **No packets will be accepted after September 1st.** All pages are to be signed and submitted. Package can be found on the website.

IMMUNIZATION POLICY

Beth Torah Benny Rok Campus is mindful about the health of all members of our community. Immunizations are required in order for your child to attend the program and we must receive all up-to-date forms by September 1st. Expired forms will not be accepted.

All forms must be submitted together along with a parent signature and staff signature approving the packet submission.

Your child will not be permitted to start the program without all the required paperwork.

Please do not hesitate to contact the school by email: grascovsky@btbrc.org if you have any questions regarding forms.

B'Shalom,

Dr Gabriela Rascovsky
Director of Lifelong Learning



Submitting a Complete “My journey packet”

Beth Torah Benny Rok Campus, the Florida Department of Health, and the Department of Children and Families require the documents listed below. They must be submitted electronically to the School office, by **September 1, 2022.**

- Office Information Form
- Acknowledgement Card
- Emergency Health Form (pgs. 1 & 2)**
 - **Health Insurance Policy information must be included or a Photo Copy of the Health Insurance Card (page 2).**
- Medical Authorization for OTC Medication Form (pgs. 3 & 4)
 - Page 3 is OPTIONAL, Doctor’s signature required
 - Page 4 MUST have a signed treatment order to start school whether or not you are planning to use medications during the school day. If you do not want your child medicated by the Nurse at school please indicate this on the form.
- Authorization for Administration of Prescription Medication *OPTIONAL, Doctor’s signature required*
- Food Allergy Action Plan *OPTIONAL, Doctor’s signature required*
- A copy of the Immunization Form (DH680) – this form is supplied by your physician or health care provider. This form must show all current immunizations. **NO RELIGIOUS EXEMPTIONS WILL BE ACCEPTED.**
- Zoom Etiquette for students

Student Name: _____

Parent Name and Signature: _____

Date: _____



OFFICE INFORMATION FORM 2022-2023

Child's Last Name: _____ First Name: _____ Sex: M _____ F _____

Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Mother or Guardian's

Father or Guardian's

Full Name: _____

Full Name: _____

Work #: _____

Work #: _____

Cellular #: _____

Cellular #: _____

E-mail: _____

E-mail: _____

People authorized to pick up my child:

NAME

PHONE NUMBER

RELATIONSHIP

NAME	PHONE NUMBER	RELATIONSHIP

People **Not Permitted** To Pick Up:

Carpool Arrangement: Please complete which other Family will Pick Up your child/ren every Wednesday

Pediatrician's Name: _____ Phone #: _____

Other people to be notified in case of illness or accident:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

May Scheck Family Religious School contact another physician if unable to contact yours?

Yes: _____ No: _____

Parent or Guardian(s) Signature

Date



Beth Torah Benny Rok Campus

J2M
ACKNOWLEDGEMENT CARD
2022-2023

PLEASE PRINT LEGIBLY
SIGN AND RETURN TO THE PROGRAM ADMINISTRATOR

Table with 2 columns: Child(ren) Name(s), Teacher /Program. Contains 4 empty rows for data entry.

We have received, read and accept the following:

[] J2M PARENT HANDBOOK 2022-2023 - We agree to follow and abide by all rules, requirements and procedures.

[] PERMISSION TO ALLOW E-MAIL CONTACT
You may contact me via e-mail for periodic updates, news, and information.

E-MAIL ADDRESS(ES) _____

[] In the event of an emergency and where it is deemed necessary to evacuate the building, I give permission for J2M to transport my child to another location. I release J2M and Beth Torah from any and all liability relating to such transport.

I have read all of the above and I am providing consent by checking the appropriate boxes above.

Parent's Signature _____

Parent's Printed Name _____ Date _____
First and Last





EMERGENCY HEALTH FORM 2022 - 2023

(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 during J2M hours

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 J2M hours? ___Yes ___No

*If yes, please specify: _____

* Please contact the program administrator if the answer is yes to set up a health care plan.

6. List any additional information that you would like the program administration to know about your child:





EMERGENCY HEALTH FORM 2022 – 2023

The health services at J2M 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 program administrator. 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: _____