

EMERGENCY RELEASE INFORMATION
(ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL)

STUDENT NAME _____ LIST ANY LONG-TERM MEDICATIONS _____ _____ DOSAGE _____ CONDITION _____ WILL IT BE TAKEN AT SCHOOL? Y___ N___ MANNER ADMINISTERED _____ CAN CHILD ADMINISTER? Y___ N___ IF NO, WHO CAN? _____ OTHER HEALTH INFORMATION: <input type="checkbox"/> NO KNOWN HEALTH PROBLEMS <input type="checkbox"/> ASTHMA <input type="checkbox"/> EPILEPSY <input type="checkbox"/> HEART CONDITION <input type="checkbox"/> VISION PROBLEMS <input type="checkbox"/> HEARING PROBLEMS <input type="checkbox"/> ALLERGIES FOODS _____ MEDICATIONS _____ BEE STINGS _____ TREATMENT NEEDED _____ <input type="checkbox"/> ADD / ADHD _____ <input type="checkbox"/> OTHER (PLEASE SPECIFY) _____ _____ <input type="checkbox"/> ANY SIGNIFICANT LIFE CHANGES OR DISRUPTIONS ABOUT WHICH WE SHOULD BE AWARE _____ _____ <input type="checkbox"/> ANY LEARNING ISSUES _____ _____ _____	STUDENT NAME _____ LIST ANY LONG-TERM MEDICATIONS _____ _____ DOSAGE _____ CONDITION _____ WILL IT BE TAKEN AT SCHOOL? Y___ N___ MANNER ADMINISTERED _____ CAN CHILD ADMINISTER? Y___ N___ IF NO, WHO CAN? _____ OTHER HEALTH INFORMATION: <input type="checkbox"/> NO KNOWN HEALTH PROBLEMS <input type="checkbox"/> ASTHMA <input type="checkbox"/> EPILEPSY <input type="checkbox"/> HEART CONDITION <input type="checkbox"/> VISION PROBLEMS <input type="checkbox"/> HEARING PROBLEMS <input type="checkbox"/> ALLERGIES FOODS _____ MEDICATIONS _____ BEE STINGS _____ TREATMENT NEEDED _____ <input type="checkbox"/> ADD / ADHD _____ <input type="checkbox"/> OTHER (PLEASE SPECIFY) _____ _____ <input type="checkbox"/> ANY SIGNIFICANT LIFE CHANGES OR DISRUPTIONS ABOUT WHICH WE SHOULD BE AWARE _____ _____ <input type="checkbox"/> ANY LEARNING ISSUES _____ _____ _____
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IF MY CHILD IS ILL OR HAS AN EMERGENCY AND I CANNOT BE REACHED, PLEASE CALL AND RELEASE MY CHILD IN ORDER OF PREFERENCE TO:

NAME _____ PHONE _____

RELATIONSHIP _____ CELL PHONE _____

NAME _____ PHONE _____

RELATIONSHIP _____ CELL PHONE _____

IN CASE OF AN ACCIDENT OR SUDDEN ILLNESS, WHEN A PARENT OR GUARDIAN IS UNAVAILABLE, I AUTHORIZE A TEMPLE OR RISHON REPRESENTATIVE TO OBTAIN MEDICAL CARE FOR MY CHILD, INCLUDING NECESSARY TRANSPORTATION, IN ACCORDANCE WITH THEIR BEST JUDGMENT. I FURTHER AUTHORIZE THE DOCTOR NAMED BELOW TO PROVIDE THE CARE AND TREATMENT HE/SHE CONSIDERS NECESSARY. IF THE PHYSICIAN DESIGNATED BELOW IS UNAVAILABLE, I AUTHORIZE SUCH CARE AND TREATMENT TO BE PERFORMED BY A LICENSED PHYSICIAN SELECTED BY THE TEMPLE REPRESENTATIVE. I AGREE TO PAY ALL COSTS INCURRED AS A RESULT OF THE FOREGOING.

MEDICAL INSURANCE PLAN _____ GROUP # _____

MEDICAL/PATIENT ID NUMBER(S) _____

DOCTOR NAME _____ PHONE _____

DENTIST NAME _____ PHONE _____

PARENT NAME (PRINT)

PARENT SIGNATURE

OTHER ADULTS **NOT** AUTHORIZED TO PICK CHILD UP FROM SCHOOL

NAME _____

NAME _____