



Emergency Information & Medical Release 2022/2023

PERSONAL INFORMATION

Child's Name:			Sex: <input type="checkbox"/> Male or <input type="checkbox"/> Female		
Age:	Date of Birth:	School Grade:	Religious School Grade:		
Address:			City/Zip:		
Mother's Name:					
Email:			Main Phone: () -		
Address (If Different):					
Occupation:			Employer:		
Father's Name:					
Email:			Main Phone: () -		
Address (If Different):					
Occupation:			Employer:		
Child's Physician:			Main Phone: () -		
Address:			City/Zip:		
Insurance Company:			Policy #:		
Allergies:					
Medications:					
<input type="checkbox"/> It is understood that my child _____ is in good physical health and has my permission to participate in all activities that are part of the regular Religious School program					
<input type="checkbox"/> I hereby authorize the Education Director or agents of Beth El Religious School to make available to my child _____ professional medical care if such care is needed.					
<input type="checkbox"/> It is understood that every effort will be made to notify me, my spouse, or designated emergency contact 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. I give my permission for my child to receive proper medical treatment by any doctor, nurse, and paramedic or hospital medical staff licensed by the State of Florida.					
Parent Signature:			Date:		
Emergency Contact (other than parent) Name:					
Relationship:			Main Phone: () -		