



*Calabasas Hebrew School*

## Emergency Medical Information

Child's Name \_\_\_\_\_  
Last Name First Name

Date of Birth \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone Father ( ) \_\_\_\_\_ Cell Phone Mother ( ) \_\_\_\_\_

Childs' Doctor \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Childs' Dentist \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Health Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Please indicate any known allergies:

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Emergency Contact in case parents are unavailable:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Relationship to Student \_\_\_\_\_

Has or is subject to: (check and give details)

- Asthma             Convulsions             Heart trouble  
 Diabetes             Fainting             High blood pressure  
 Allergies             Contact lenses  
 Any other condition that may require emergency or special care.

Explain: \_\_\_\_\_  
\_\_\_\_\_

### Medical History

Date of most recent physical exam (month and year) \_\_\_\_/\_\_\_\_

Does your child have any current health problems?  Yes  no

Is your child now under medical care or taking any medicines?  
 Yes  no

Explain any "yes" answers in the space below.

\_\_\_\_\_  
\_\_\_\_\_

### Parent's Authorization

To the best of my knowledge, history is correct and complete. I know of no reason to restrict activity and I give my permission for participation in all activities and trips except as specifically noted herein. In the event that I cannot be reached in an emergency, I hereby give permission to the administration and/or physician selected by the school to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Parent's Signature: \_\_\_\_\_