

Beth Israel Hebrew School Emergency Form

Please fill out one form for each family.

Last Name _____

Address _____

Home Phone _____

Mother's Name _____

Address/Phone _____ Work/Cell Phone _____

Father's Name _____

Address/Phone _____ Work/Cell Phone _____

Child(ren) Names/ Date of Birth:

Who is permitted to take your child from Hebrew School?

Name _____ Phone _____

Name _____ Phone _____

Doctor _____

Address/Phone _____

Insurance _____

Allergies: Please state any Allergies that we should be aware of:

Medical Conditions: _____

"I hereby give my consent, in the event of a medical emergency when I cannot be contacted, for Hebrew School staff to obtain whatever treatment may be deemed necessary for my child, _____."

Signed _____