

CHABAD HEBREW SCHOOL ג"ה
2016 - 2017

CHILD'S NAME: *(last, first)* _____

◆ In case of emergency, when neither parent can be reached, give names of two people who will take responsibility for your child.

Name _____ Name _____

Phone _____ Phone _____

Relationship to student _____ Relationship to student _____

◆ If parents cannot be reached and emergency medical advice is needed, permission is given to the Hebrew School staff to phone my child's doctor:

Doctor _____ Phone _____

Doctor's hospital affiliation

◆ In case of medical emergency requiring immediate emergency care, I authorize the paramedics to take my child to the nearest hospital, if necessary.

◆ **FURTHER MEDICAL INFORMATION**

Allergic reactions to medication

Medication child is taking on a regular basis

Any special medical condition or allergy

Signature of Parent _____ Date ___/___/___

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2015 - 2016

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