



Student: \_\_\_\_\_  
 Grade: \_\_\_\_\_  
 Teacher: \_\_\_\_\_



## Kehilla School Emergency Contact Form

**Important note:** *Students may not attend Kehilla School until this form is completed and returned.*

<b>EMERGENCY CONTACT INFORMATION:</b>		
<b>Parent #1:</b>		
Cell Phone:	Work/Additional Phone:	Home Phone:
<b>Parent #2:</b>		
Cell Phone:	Work/Additional Phone:	Home Phone:

Doctor's Name:		Child's date of birth:	
Phone:		Fax:	
Address:			
City		State:	Zip
Insurance Company	Insurance Policy #	Effective dates:	

**ALLERGIES:**

My child has no known allergies.  
 My child has an allergy to the following food(s): \_\_\_\_\_  
 This causes anaphylaxis:  yes  no  
 Describe reaction if food is eaten and what is done to manage it:

My child is allergic to the following medication(s): \_\_\_\_\_  
 \_\_\_\_\_  
 My child is allergic to the following substance(s): \_\_\_\_\_  
 \_\_\_\_\_  
 My child has the following chronic health condition(s): \_\_\_\_\_

Please provide supportive health information about the condition, your concerns, and what we can/should do:

My child is on the following medication\*:  
 \*Kehilla staff will NOT administer medication, except in an emergency situation, unless we have explicit permission from parents.

What else would you like us to know about your child's health and well-being? (Use separate paper if needed)

**(Please complete other side!)**

While your child is in our care, an accident, emergency, or illness may occur that requires immediate medical attention without sufficient time to contact parents/guardians. The California Legislature has authorized consent in advance by parents or legal guardians for such treatment (Family Code Section 6910).

<b>Emergency Contact Person #1:</b>	
Phone #	Additional Phone:
Relationship to Child:	
Is this person authorized to pick up your child?	
<b>Emergency Contact Person #2:</b>	
Phone #	Additional Phone:
Relationship to Child:	
Is this person authorized to pick up your child?	

Who else is authorized to pick up your child? Name:	Phone number:
Name	Phone number:

### **Authorization to Consent to Treatment of a Minor**

I hereby authorize the Kehilla Community Synagogue/School representative to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment or hospital care that is deemed advisable by, and is to be rendered under the supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act or to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment or hospital care that is deemed advisable by, and is to be rendered under the supervision of any dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, hospital, or otherwise.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of said agent(s) to give specific consent to any and all such diagnosis, treatment and hospital care that such physician or dentist in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Family Code Section 6550-6552 of California and shall remain effective until revoked. It is understood that every effort will be made by Kehilla Community Synagogue/School to contact me before exercising this authorization.

I hereby authorize Kehilla Community Synagogue/School to engage for my child \_\_\_\_\_ at my expense any necessary emergency medical or dental care, until I can be informed and make further arrangements. I hereby incorporate by reference the "Authorization to Consent to Treatment of a Minor" as set forth above. This authorization will expire on June 30, 2008.

PRINT Parent/Guardian Name: \_\_\_\_\_  
 Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(Please complete other side!)**