

FJCC HEBREW SCHOOL
2009-2010 EMERGENCY MEDICAL RELEASE FORM

Student's Name: _____ Date of Birth: _____

Address:

Home Telephone: _____

Father's Name: _____ **Work Tel. No.** _____

Cellular No. _____

Mother's Name: _____ **Work Tel. No.** _____

Cellular No. _____

Child's

Physician: _____ Telephone: _____

Name of health/accident insurance

carrier: _____

Policy No: _____ Telephone No. _____

Known allergies or medical problems.

In the event of serious injury or medical emergency, I hereby give permission for my child to be attended to with the necessary first aid and in the event I cannot be contacted I give my permission for my child _____ to be transported to the nearest hospital emergency room and given whatever aid is necessary.

Signature Of Parent Or Guardian

Date

In the event I am unavailable please contact (please choose someone who lives close by):

1. _____
NAME ADDRESS TELEPHONE

2. _____

NAME

ADDRESS

TELEPHONE

3.

NAME

ADDRESS

TELEPHONE

Q **SEE REVERSE FOR ADDITIONAL INFORMATION.**