

HILLEL DAY SCHOOL OF BOCA RATON

EMERGENCY AUTHORIZATION, 2011-2012

FAMILY INFORMATION:

_____ MR. ___ DR. ___ RABBI ___ MRS. ___ DR. ___ MS. ___
 (LAST NAME) (CHECK ONE) (FATHER'S FIRST NAME) (CHECK ONE) (MOTHER'S FIRST NAME)

_____ LEGAL GUARDIAN: FATHER MOTHER BOTH OTHER _____
 (MOTHER'S LAST NAME, if different)

_____ (HOME ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

_____ (MOTHER'S ___ / FATHER'S ___ [check one] HOME ADDRESS, if different)

_____ (HOME PHONE NUMBER) _____ (FATHER'S CELL PHONE#) _____ (MOTHERS CELL PHONE#) _____ (FATHER'S WORK PHONE#)

_____ (MOTHER'S WORK PHONE#) _____ (OTHER, please specify)

STUDENT INFORMATION:

1) _____ (FULL NAME) _____ (GRADE) _____ (BIRTHDATE)

2) _____ (FULL NAME) _____ (GRADE) _____ (BIRTHDATE)

3) _____ (FULL NAME) _____ (GRADE) _____ (BIRTHDATE)

4) _____ (FULL NAME) _____ (GRADE) _____ (BIRTHDATE)

5) _____ (FULL NAME) _____ (GRADE) _____ (BIRTHDATE)

6) _____ (FULL NAME) _____ (GRADE) _____ (BIRTHDATE)

EMERGENCY INFORMATION:

LOCAL CONTACTS (OTHER THAN MOTHER OR FATHER):

1) _____ 2) _____
(NAME) (PHONE) (RELATIONSHIP) (NAME) (PHONE) (RELATIONSHIP)

CHILD(REN)'S DOCTOR _____ TELEPHONE _____ FAX _____

CHILD(REN)'S DENTIST _____ TELEPHONE _____ FAX _____

MEDICAL INFORMATION:

STUDENT'S NAME: _____ MEDICATIONS (at home or school): DAILY: _____ AS NEEDED: _____

ALLERGIES (please specify): _____ SPECIAL HEALTH PROBLEMS (please explain): _____

STUDENT'S NAME: _____ MEDICATIONS (at home or school): DAILY: _____ AS NEEDED: _____

ALLERGIES (please specify): _____ SPECIAL HEALTH PROBLEMS (please explain): _____

STUDENT'S NAME: _____ MEDICATIONS (at home or school): DAILY: _____ AS NEEDED: _____

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STUDENT'S NAME: _____ MEDICATIONS (at home or school): DAILY: _____ AS NEEDED: _____

ALLERGIES (please specify): _____ SPECIAL HEALTH PROBLEMS (please explain): _____

STUDENT'S NAME: _____ MEDICATIONS (at home or school): DAILY: _____ AS NEEDED: _____

ALLERGIES (please specify): _____ SPECIAL HEALTH PROBLEMS (please explain): _____

I GIVE PERMISSION FOR THE FOLLOWING PEOPLE TO REMOVE MY CHILD FROM SCHOOL:

1) _____ (NAME) _____ (PHONE) _____ (RELATIONSHIP) 2) _____ (NAME) _____ (PHONE) _____ (RELATIONSHIP)

IN AN EMERGENCY SITUATION OR IF I CANNOT BE REACHED, I HEREBY AUTHORIZE THE STAFF OF HILLEL DAY SCHOOL OF BOCA RATON TO SEEK APPROPRIATE MEDICAL TREATMENT FOR MY CHILD(REN) AT THE NEAREST AVAILABLE HOSPITAL.

(SIGNATURE OF PARENT)

(DATE)