

ALLERGY/MEDICATION AND MEDICAL FORM

CONFIDENTIAL INFORMATION

Completed forms will be kept in the Jarson Education Center Office
2010-2011/5771

Student's Name _____

Please complete a separate form for each student.

Does this student have ANY food allergies or sensitivities? Please specify.	
What medications is this student currently taking?	
Please note any medical/physical concerns of which we should be aware.	
Does this student have ANY environmental or seasonal allergies (I.e. hay fever)?	
Does this student have any food restrictions apart from allergies?	
What Medications (prescribed or over the counter) might your child need to self-administer during school hours? PLEASE MAKE SURE A NOTE FROM A PARENT OR GUARDIAN ACCOMPANIES ALL SUCH MEDICATION.	

Consent for Emergency Medical Treatment

Sign either part A or B:

A. We, the parents of _____, give permission for emergency medical or dental treatment of our child for illness or accident if we cannot be contacted. We assume the responsibility for payment of treatment. Of course, in the event of an emergency, every effort will be made by Adath Israel to reach the parents or their proxy before treatment, if at all possible.

Emergency contacts:

Parent 1. _____

Parent 2. _____

Alternate Emergency contact _____

Child's relationship to emergency contact _____

Medical Doctor _____

Dentist _____

Health Insurance _____ Policy # _____

Parent/Guardian _____ Date _____

B. I do not give my consent for emergency medical treatment for my child.

Parent/Guardian _____ Date _____