PLEASE TYPE OR WRITE CLEARLY

Emergency Health Information Sheet (One per family)

FORM B

If there are any custody issues, please provide the office proper legal documentation.

	CHILD 1	CHILD 2	CHILD 3
Child's Name			
Date of Birth			
Child resides with			
Congregation Shalom School Grade			
Allergies (Bee, Insect, Food, Environmental, Other)			
* Epi-Pen prescribed by MD? Yes/ No	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
* Inhaler prescribed by MD? Yes/No	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
Please list the correlating number of any conditions that apply from the list below			

1. ADD /ADHD	4. Anxiety	7. Arthritis	10. Asthma	13. Bladder Control	16.Constipation
2. Developmental Delay	5. Diabetic	8. Gastric reflux	11. Hearing Loss	14. Heart Issues	17. Kidney
3. Migraines	6. Nosebleeds	9. Panic/Anxiety	12. Seizures	15. Glasses/Contact Lenses	18. Other (explain)

Please comment on any family / emotional / health issues and / or past medical problems that can help the school care for your child.			
Does the student have any physical limitations? Yes/No (If yes, please list)			
If your child suffers an allergic reaction, do we have your permission to administer Benadryl? Yes/No	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
Please list all medications your child takes at school or home. (For monitoring side effects) ** Medication / Time of Day / Dose			

IF YOUR CHILD USES AN EPI-PEN, INHALER OR HAS SEVERE ALLERGIES YOU MUST COMPLETE FORM E

In case of Emergency, which parent should be contacted first? ◯ Parent1 ◯ Parent 2

NAME	PHONE 1	PHONE 2
Parent 1:		
Parent 2:		

Emergency contact information (if parent cannot be reached). Please list two.

NAME	RELATIONSHIP	PHONE 1	PHONE 2
1.			
2.			

Primary Care Provider:	PCP Phone #:	Desired Hospital:	
Insurance Company:	Insurance Policy #:	Dentist:	Phone #

**Medications necessary to be given during the school day, either daily or as needed, must have a written physician's order, written parental permission, and be supplied and delivered by parent in the original container. This applies to prescription and non-prescription medications.

This information is accurate. I understand that in case of injury, the school is responsible for First-Aid treatment only. I also understand that the school will share confidentially with appropriate personnel, medical information deemed necessary in order to provide optimum safety for my child.

Parent's signature_____Date_____

MEDICAL RELEASE

I authorize Congregation Shalom to take measures deemed necessary to seek or administer medical treatment for my child in the event of any emergency. This authorization applies to incidents at the school and/or on field trips. I understand that I will be contacted immediately, as will my child's physician.

Parent's signature_____Date_____