

**OHR HATORAH RELIGIOUS SCHOOL
STUDENT MEDICAL INFORMATION FORM**

THIS FORM CONSISTS OF FOUR SECTIONS. IN ORDER TO BE ADMITTED TO VISIT OHR HATORAH RELIGIOUS SCHOOL ON _____, EACH SECTION NEEDS TO BE COMPLETED WITH THE REQUIRED SIGNATURES AND BE RETURNED TO THE OHR HATORAH RELIGIOUS SCHOOL DESK ON SITE BEFORE THE CHILD ENTERS THE CLASSROOM.

NAME OF PARTICIPANT _____

I. PARENT'S WAIVER

We (I) hereby give permission for the above named student to attend Ohr HaTorah Religious School. We (I) hereby release and discharge the Ohr HaTorah Synagogue, its officers, directors, instructors and employees, from any and all claims, demands, actions or cause of action that we (I) may or shall have reason of any illness, injury or accident incurred or suffered by the above named participant at the Ohr HaTorah Religious School, no matter how caused or occasioned.

Names of Parents or Guardians (please print) _____
(Circle one)

Signature of Parents/Guardians _____ Date _____

_____ Date _____

Daytime Contact Number: _____ Evening Contact Number: _____

II. INSURANCE

Ohr HaTorah Synagogue does not carry medical insurance to cover participants. All participating students should be covered by personal or family insurance. We (I) hereby certify, under penalty of perjury, that the above named student(s) has medical insurance coverage.

Names of Parents/Guardians (please print) _____

Signature of Parents/guardians _____

Insurance Company _____

Policy/Group Number _____ Expiration Date of Insurance _____

Please list emergency number(s) other than those above at which parent, guardian, or another relative may be reached during the Retreat.

(Please print name and relationship to student)

Name: _____ Telephone: (____) _____

Name: _____ Telephone: (____) _____

III. PARENTS CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event that our (my) child _____ becomes ill or sustains an injury while under the supervision of the Ohr HaTorah staff and volunteers, we (I) hereby give permission to administer first aid to our (my) child's relief. If it is not practical to return our (my) child to us (me), or to receive our (my) instructions for his/her care, consent is given to any licensed physician and/or surgeon to perform such surgical procedures as the licensed physician and/or surgeon shall think the existing emergency requires for the relief of pain and to preserve our (my) child's life and health. We (I) understand and agree that while the Ohr HaTorah staff may seek medical treatment for our (my) child, we (I) hereby release and discharge the Ohr HaTorah Synagogue, its officers, agents, instructors and employees, from any and all claims demands, suits, actions or cause of actions that we (I) may or shall have by reason or arranging for such medical treatments or from failure to seek such medical treatments.

Names of Parents or Guardians (please print): _____

Signature of Patents / Guardians _____ Date: _____

_____ Date: _____

IV. STUDENT MEDICAL HISTORY

Name of Participant: _____ Birth Date _____

Address: _____

City: _____ State : _____ Zip Code: _____

Has been examined and is in good health. In addition, the health, history, and immunization records have been reviewed. There are no objections to participating for health related reasons.

Date of most recent exam: _____ Weight: _____ Height: _____

Date of most recent tetanus toxoid immunization: _____

Doctor's Name: _____ Date: _____

Doctor's Address: _____

Doctor's Telephone: () _____

MEDICAL HISTORY (give dates)

	<u>ALLERGIES</u>	<u>DISEASES</u>
Frequent Ear Infections _____	Hay fever _____	Chicken Pox _____
Heart Defect/Disease _____	Ivy poisoning, etc. _____	Measles _____
Convulsion _____	Insect stings _____	German Measles _____
Diabetes _____	Asthma _____	Mumps _____
Bleeding _____		
Clotting Disorders _____		
Hypertension _____		
Mononucleosis _____		
Hepatitis _____		
TB _____		

Food Allergies _____

Current Medication: _____

Medication Allergies: _____