

**SHALOM SCHOOL 2020-2021  
FAMILY/EMERGENCY INFORMATION FORM**

**CHILD(REN)'S LAST NAME:** \_\_\_\_\_

**Student 1 Name** \_\_\_\_\_  Boy  Girl Birthdate \_\_\_\_\_ Class/Grade \_\_\_\_\_

**Student 2 Name** \_\_\_\_\_  Boy  Girl Birthdate \_\_\_\_\_ Class/Grade \_\_\_\_\_

**Student 3 Name** \_\_\_\_\_  Boy  Girl Birthdate \_\_\_\_\_ Class/Grade \_\_\_\_\_

Home Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Parent/Legal Guardian 1 Name** \_\_\_\_\_ Email \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Address (IF DIFFERENT FROM ABOVE) \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**Parent/Legal Guardian 2 Name** \_\_\_\_\_ Email \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Address (IF DIFFERENT FROM ABOVE) \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

If you are affiliated with a congregation, please indicate – Name \_\_\_\_\_ City \_\_\_\_\_

**GRANDPARENT INFORMATION** (USED FOR INVITATIONS TO SPECIAL EVENTS, SHARING SCHOOL INFORMATION, AND ONE SOLICITATION PER YEAR)

Grandparent Name(s) \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip Code \_\_\_\_\_ Email Address \_\_\_\_\_

Grandparent Name(s) \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip Code \_\_\_\_\_ Email Address \_\_\_\_\_

**The following persons are authorized to be contacted regarding my child if I am unavailable during an emergency.**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

**The following persons are authorized to pick up and/or transport my child(ren).** (MAY BE THE SAME OR DIFFERENT THAN EMERGENCY CONTACTS.)

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

**MEDICAL & INSURANCE INFORMATION**

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Hospital Preference \_\_\_\_\_ Medical Plan \_\_\_\_\_ Plan Number \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

**INDIVIDUAL STUDENT INFORMATION:**

**Student 1 Name:** \_\_\_\_\_

**Please check the spaces pertaining to your child:**  My child has no known health problems

Born prematurely (before 37 weeks)  Wears glasses/contacts  Has a hearing problem  Tubes in ears  Requires preferential seating

**GENERAL HEALTH** - My child has the following conditions:  Asthma  Seizures  Migraines  Diabetes  Heart Condition

Other \_\_\_\_\_  Allergies (describe) \_\_\_\_\_

Are any of the above life-threatening?  No  Yes (explain) \_\_\_\_\_

My child has a physical condition which limits participation in:  Classroom activities  Physical education (Please explain)

**MEDICATIONS** - List all medications prescribed \_\_\_\_\_

Current dosage \_\_\_\_\_ for (diagnosis) \_\_\_\_\_

**\* IF YOUR CHILD WILL BE TAKING ANY MEDICATIONS WHILE AT SCHOOL ON A REGULAR OR AS-NEEDED BASIS PLEASE COMPLETE THE PARENT/PHYSICIAN MEDICATION CONSENT FORM AND RETURN IT TO THE SHALOM SCHOOL OFFICE SIGNED BY A PHYSICIAN.**

**Student 2 Name:** \_\_\_\_\_

**Please check the spaces pertaining to your child:**  My child has no known health problems

Born prematurely (before 37 weeks)  Wears glasses/contacts  Has a hearing problem  Tubes in ears  Requires preferential seating

**GENERAL HEALTH** - My child has the following conditions:  Asthma  Seizures  Migraines  Diabetes  Heart Condition

Other \_\_\_\_\_  Allergies (describe) \_\_\_\_\_

Are any of the above life-threatening?  No  Yes (explain) \_\_\_\_\_

My child has a physical condition which limits participation in:  Classroom activities  Physical education (Please explain)

**MEDICATIONS** - List all medications prescribed \_\_\_\_\_

Current dosage \_\_\_\_\_ for (diagnosis) \_\_\_\_\_

**\* IF YOUR CHILD WILL BE TAKING ANY MEDICATIONS WHILE AT SCHOOL ON A REGULAR OR AS-NEEDED BASIS PLEASE COMPLETE THE PARENT/PHYSICIAN MEDICATION CONSENT FORM AND RETURN IT TO THE SHALOM SCHOOL OFFICE SIGNED BY A PHYSICIAN.**

**\*\*If you have more than two children, please fill out the Supplemental Medical Form**  Supplemental Medical Form Is Attached

**AUTHORIZATION TO TREAT MINOR**

Should it become necessary for my/our child(ren) listed above to receive medical treatment while participating in any school related class, event, field trip, or activity, I/we hereby authorize the school staff to secure reasonable treatment including transportation for my/our child(ren). I/we do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care is considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services. This authorization is given in accordance with Section 4907 of the California Education Code and shall remain effective until revoked in writing and delivered to the principal or designee.

I/we certify that I/we have read and understood this form and hereby give my/our authorization for emergency medical treatment, and that all of the information I/we have provided on this form is true and correct.

I/we do not choose the above statement. I/we desire the following action to be taken in the event of an emergency \_\_\_\_\_

Parent/Legal Guardian 1 Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian 2 Signature \_\_\_\_\_ Date \_\_\_\_\_

**SHALOM SCHOOL 2020-2021**  
**Supplemental Medical Form**

**Student 3 Name:** \_\_\_\_\_

**Please check the spaces pertaining to your child:**

My child has no known health problems

Born prematurely (before 37 weeks)  Wears glasses/contacts  Has a hearing problem  Tubes in ears  Requires preferential seating

**GENERAL HEALTH** - My child has the following conditions:  Asthma  Seizures  Migraines  Diabetes  Heart Condition

Other \_\_\_\_\_  Allergies (describe) \_\_\_\_\_

Are any of the above life-threatening?  No  Yes (explain) \_\_\_\_\_

My child has a physical condition which limits participation in:  Classroom activities  Physical education (Please explain)

**MEDICATIONS** - List all medications prescribed \_\_\_\_\_

Current dosage \_\_\_\_\_ for (diagnosis) \_\_\_\_\_

**\* IF YOUR CHILD WILL BE TAKING ANY MEDICATIONS WHILE AT SCHOOL ON A REGULAR OR AS-NEEDED BASIS PLEASE COMPLETE THE PARENT/PHYSICIAN MEDICATION CONSENT FORM AND RETURN IT TO THE SHALOM SCHOOL OFFICE SIGNED BY A PHYSICIAN.**

**Student 4 Name:** \_\_\_\_\_

**Please check the spaces pertaining to your child:**

My child has no known health problems

Born prematurely (before 37 weeks)  Wears glasses/contacts  Has a hearing problem  Tubes in ears  Requires preferential seating

**GENERAL HEALTH** - My child has the following conditions:  Asthma  Seizures  Migraines  Diabetes  Heart Condition

Other \_\_\_\_\_  Allergies (describe) \_\_\_\_\_

Are any of the above life-threatening?  No  Yes (explain) \_\_\_\_\_

My child has a physical condition which limits participation in:  Classroom activities  Physical education (Please explain)

**MEDICATIONS** - List all medications prescribed \_\_\_\_\_

Current dosage \_\_\_\_\_ for (diagnosis) \_\_\_\_\_

**\* IF YOUR CHILD WILL BE TAKING ANY MEDICATIONS WHILE AT SCHOOL ON A REGULAR OR AS-NEEDED BASIS PLEASE COMPLETE THE PARENT/PHYSICIAN MEDICATION CONSENT FORM AND RETURN IT TO THE SHALOM SCHOOL OFFICE SIGNED BY A PHYSICIAN.**