SHALOM SCHOOL 2021-2022 **CHILD(REN)'S LAST NAME: _____**
FAMILY/EMERGENCY INFORMATION FORM

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 2021-2022
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.**