# 2021-2022 School Registration Form

## Parent or Guardian Information

Name(s) _____

Street Address _____

City, State, Zip _____

Phone Cell _____ Home _____

## Emergency Contact Information

Please provide the contact information of two people authorized to pick up your child in an emergency if you are not available.

| | Contact 1 | Contact 2 |
|---|---|---|
| Name | _____ | _____ |
| Relationship | _____ | _____ |
| Phone | _____ | _____ |
| Text | _____ | _____ |

## Child's Medical Information

Name of primary doctor _____

Doctor's phone number _____

Doctor's office address _____

Preferred hospital _____

Insurance carrier _____

Insurance policy number _____ ID number _____

Allergies (food, drugs, insects, etc.) _____

_____

Medical issues or conditions _____

_____

_____

Current medications _____

_____

# AUTHORIZATION TO TREAT A MINOR

I/We the undersigned parent(s) or legal guardian(s) of _____, a minor, do hereby authorize and consent to any X-ray examination, anesthetic, medical, or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff of any acute general hospital holding a current license to operate as a hospital from the state of Arizona.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required and is given to provide authority and power to render care which the aforementioned or attending physician, in the exercise of her/his best judgment, may deem advisable. It is understood that effort shall be made to contact the undersigned prior to transporting the student to an emergency facility or the rendering of treatment to the patient to such facility, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

This consent shall remain effective until rescinded.

Signature of parents(s) or guardian(s): _____ Date: _____

_____ Date: _____

YOU ARE PRESUMED TO HAVE CONSENTED TO EMERGENCY TREATMENT TO PRESERVE LIFE OR LIMB.

Complete this section ONLY if you refuse consent for emergency medical treatment:

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to do the following:

_____

_____

_____

_____

Signature of parents(s) or guardian(s): _____ Date: _____

_____ Date: _____

# **PHOTOGRAPH RELEASE** (One per family)

From time to time we take photographs of children involved in school activities to use for display in-house or as part of promotional materials. We would like permission for this use.

I/We give my permission for photographs to be taken of my child(ren), _____

_____)_____

to be used in publications of Congregation Chaverim for promotional purposes.

Signature of parents(s) or guardian(s): _____ Date: _____

_____ Date: _____