

**Congregation Shaar Hashalom  
Religious School  
2019-2020 Medical Release Form**

**Please, complete this page for each child enrolled in the Religious School**

**NAME OF MINOR:** \_\_\_\_\_  
(Please print)

In the event of an emergency, **I,** \_\_\_\_\_  
(Please print)

**(Relationship)** \_\_\_\_\_  
(Please print)

authorize the representative of Congregation Shaar Hashalom to act on my behalf to approve such medical treatment including, without limitation, x-ray, examination, anesthetic, medical, dental, or surgical examination or treatment and general hospital care.

**Known Allergies:** \_\_\_\_\_

**Medical Conditions:** \_\_\_\_\_

**I SPECIFICALLY CERTIFY THAT:**

This authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of Congregation Shaar Hashalom to give specific consent to any and all such examinations, treatment, or Hospital care.

The possession of the original of this Authorization by the congregation is evidence that the representative of Congregation Shaar Hashalom has care and control of such minor and that I cannot be contacted.

This Authorization shall remain effective for a period of one (1) year from its signing, unless sooner revoked by the physical destruction of the original hereof, such destruction being the only method of actual notice of the revocation of same.

I am the person having the power to consent to medical treatment of such minor, and assume the responsibility for the payment of such treatment

All blanks of this Authorization were filled in before I signed this Authorization.

**Parent/Guardian  
Signature:** \_\_\_\_\_

**Date**    \_\_\_\_ / \_\_\_\_ / \_\_\_\_