

Studio @ Sherith Israel Health & Safety Form 2019–2020

Student Information, Health Conditions & Learning Profile

Student #1 Information

Full Name		Hebrew Name	
Date of Birth		Grade	
Secular School		Email	

Student #1 Health Conditions & Learning Profile

Does your child have any health conditions that we should know about? (food allergies, EpiPen, asthma, etc)?

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Does your child have any conditions that may impact his/her education experience? (visual, hearing, speech-language, anxiety, ADD, ADHD, etc)?

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Does your child receive any special accommodations (IEP) in their secular school setting? **If yes, please attach the materials so that we may better serve your child.**

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Student #2 Information

Full Name		Hebrew Name	
Date of Birth		Grade	
Secular School		Email	

Student #2 Health Conditions & Learning Profile

Does your child have any health conditions that we should know about? (food allergies, EpiPen, asthma, etc)?

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Does your child have any conditions that may impact his/her education experience? (visual, hearing, speech-language, anxiety, ADD, ADHD, etc)?

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Does your child receive any special accommodations (IEP) in their secular school setting? **If yes, please attach the materials so that we may better serve your child.**

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Student Information, Health Conditions, & Learning Profile

Student #3 Information

Full Name		Hebrew Name	
Date of Birth		Grade	
Secular School		Email	

Student #3 Health Conditions & Learning Profile

Does your child have any health conditions that we should know about? (food allergies, EpiPen, asthma, etc)?

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Does your child have any conditions that may impact his/her education experience? (visual, hearing, speech-language, anxiety, ADD, ADHD, etc)?

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Does your child receive any special accommodations (IEP) in their secular school setting? **If yes, please attach the materials so that we may better serve your child.**

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Student #4 Information

Full Name		Hebrew Name	
Date of Birth		Grade	
Secular School		Email	

Student #4 Health Conditions & Learning Profile

Does your child have any health conditions that we should know about? (food allergies, EpiPen, asthma, etc)?

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Does your child have any conditions that may impact his/her education experience? (visual, hearing, speech-language, anxiety, ADD, ADHD, etc)?

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Does your child receive any special accommodations (IEP) in their secular school setting? **If yes, please attach the materials so that we may better serve your child.**

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Parent Information

Parent/Guardian #1		Parent/Guardian #2	
Name		Name	
Email		Email	
Phone		Phone	
Address		Address <input type="checkbox"/> same as #1	

Emergency Contacts

Please List Two Other People Who Are Authorized to Take Your Child in Case of Emergency

Contact #1		Contact #2	
Name		Name	
Phone		Phone	
Relationship		Relationship	

Consent and Liability Waivers

Promotional Permission

I DO NOT wish for Studio @ Sherith Israel and associated youth groups and its agents/sponsors to use my child's photograph for future promotions.

Directory Inclusion

I DO authorize Sherith Israel to publish the following contact information in a Studio directory, to be circulate to all Studio families:

<input type="checkbox"/> Names	<input type="checkbox"/> Parent Phone Numbers	<input type="checkbox"/> Addresses	<input type="checkbox"/> Parent Emails
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Studio Emergency Medical Release

Doctor		Doctor Phone	
Dentist		Dentist Phone	
Insurance			
I, the undersigned, authorize Congregation Sherith Israel to call a physician or seek emergency treatment as necessary for my child, in case of an emergency, and agree to pay all expenses incurred.			
Parent/Guardian Signature _____			
Date _____			

Authorizations

1. As parent(s) or legal guardian(s), I hereby give permission for the above named child to be given emergency care as administered or authorized or directed by any person acting on behalf of Congregation Sherith Israel. Such care may include x-ray examination, rendered to said minor under the general supervision and upon the advice of a physician or surgeon licensed under the provisions of the Medical Practice Act, and x-ray examination, anesthetic, dental, or surgical diagnosis, or treatment, or hospital care to be rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act, all pursuant Civil Code section 25.8. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of the child.
2. I further agree to pay the cost of all such medical or dental services.
3. It is understood that if time and circumstances reasonably permit, Congregation Sherith Israel personnel will try, but not be required, to communicate with me prior to such treatment.

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY FOR MYSELF AND MY CHILD AND A CONTRACT BETWEEN MYSELF, MY CHILD, AND CONGREGATION SHERITH ISRAEL AND ITS EMPLOYEES, OFFICERS, DIRECTORS, VOLUNTEERS, AND AGENTS, AND I HAVE SIGNED IT OF MY OWN FREE WILL.

Parent/Guardian Signature _____

Date _____