



Emergency Information 2007-2008

(This form must be completed each year.)

PLEASE MAKE SURE TO COMPLETE **EVERY** SECTION. ONE FORM PER STUDENT MUST BE RETURNED ALONG WITH YOUR SCHOOL REGISTRATION FORM, AND DEPOSIT.

Student Last Name: _____ First Name: _____ Middle Name: _____

Birthday (month/day/year) _____ Secular School: _____ **Grade:** _____

Address: _____ City: _____ Zip: _____

Phone: () _____ Email: _____

Parent 1 Name: _____ Email: _____ **Cell #:** _____

Occupation: _____ Relationship to Child: _____

Work address: _____ Work phone: _____

Parent 2 Name: _____ Email: _____ **Cell #:** _____

Occupation: _____ Relationship to Child: _____

Work address: _____ Work phone: _____

I/we wish all correspondence to be mailed to both parents.

I/we wish all correspondence to be mailed to _____ (specify).

If you are unable to reach me during any emergency, you are authorized to contact and, if necessary, to release my child to the following relative(s) or neighbor(s):

Name: _____ Address: _____ Relationship: _____ Phone: _____

Name: _____ Address: _____ Relationship: _____ Phone: _____

Name: _____ Address: _____ Relationship: _____ Phone: _____

Name: _____ Address: _____ Relationship: _____ Phone: _____

Out of state contact (**mandatory**)

Name: _____ Address: _____ Relationship: _____ Phone: _____

PLEASE COMPLETE BACKSIDE

Please describe any physical or learning disabilities which might affect the student's performance or participation (i.e, vision, hearing, speech, reading or perceptual): _____

Describe any prescription which the student takes regularly: _____

Explain: _____

Allergies: _____

Describe any family arrangements which might affect the student's attendance: _____

Medical Insurance: _____ Policy #: _____

Doctor's Name: _____ Phone #: _____

If the parent, guardian or physician cannot be reached, what action should be taken?

Call emergency hospital? yes no

Other (specify): _____

The undersigned, legal custodian of _____, a minor, hereby authorizes the Director of designee, into whose care the aforementioned minor pupil has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician or dentist.

It is understood that this authorization is given in advance of any required diagnosis, treatment or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

The undersigned hereby agrees to defend, indemnify, and hold harmless Malibu Jewish Center & Synagogue and its officers, employees and agents from any and all loss, liability charges, and expenses (including attorney fees and costs which may arise by reason of participation in any program). Malibu Jewish Center & Synagogue does not provide accident, medical, liability or workers compensation insurance for program participants. I further understand that all costs of paramedic transportation, hospitalization and any examination, x-rays, or treatment provided in relation to this authorization shall be born by the undersigned.

Signature

Print name and relationship to student

Date