Soille San Diego Hebrew Day School
Medical Information Authorization Form

Student Information

Child's Name _____ Place of Birth: _____

Weight _____ Blood Type _____ Age _____ Grade _____ Birth Date _____

Address _____ Home Phone # _____

Street City State Zip

Family Information

Father's Name _____ Work Phone # _____

Cell Phone # _____ Pager # _____ Email _____

Mother's Name _____ Work Phone # _____

Cell Phone # _____ Pager # _____ Email _____

Sibling's Name and Age _____

Doctor's Name _____ Phone # _____ Preferred Hospital_____

Health Insurance Information

Company _____ Group Name and Policy # _____ Phone # _____

Emergency Information

In case of emergency or your child becoming ill, in addition to the names listed above, please list the people the school should contact, in the order you would like them called, should we be unable to contact you. These people also have permission to check your child out of school in the case of an emergency.

Name _____ Relationship _____

Address _____ Phone #'s _____

Name _____ Relationship _____

Address _____ Phone #'s _____

Out of town relative who may be contacted in case of family separation:

Name _____ Relationship _____

Address _____ Phone #'s _____

Other health information we should know about? _____

_____

Allergies

☐ My child does not have any known allergies ☐ My child has the following allergies: _____

_____

Medication

Please speak to your doctor to arrange medications to be taken before or after school. All medications that need to be taken at school require a note from the child's doctor with complete instructions. Medications must be brought to the school office and should not be in the possession of the child. A child may have an asthma inhaler provided a note is on file in the school office and the teacher is informed.

Please read carefully and check the appropriate statements.

☐ My child **has** permission to take a non-aspirin substitute (Acetaminophen or Ibuprofen) dispensed by the school **without** first phoning his/her parent or guardian.

☐ My child **has** permission to take a non-aspirin substitute (Acetaminophen or Ibuprofen) dispensed by the school **only** if a school representative phones his/her parent or guardian first. (I understand that if the school cannot reach a parent or guardian my child will not be given any medication.)

☐ My child has permission to have **Benadryl, Diphenhydramine Hydrochloride** for an acute allergic reaction.

☐ My child has permission to have an anti-bacterial ointment applied to a cut or scrap.

I give the representatives of the Soille San Diego Hebrew Day School my authorization to obtain emergency medical treatment for my child if they believe it is needed. I, the parent/guardian, have read the above information and declare it to be true and factual as of the following date:

_____ _____

Signature of parent/guardian *Date*