Community Hebrew School of Bergen County 2022-2023

Emergency Contact/Medical Information/Photo Release

Child's Name: _____ Grade: _____

Address: _____ Home phone # _____

Public School: _____ School phone # _____

Parent #1
Name _____ Cell phone # _____ Email_____

Parent #2
Name _____ Cell phone # _____ Email_____

Emergency contacts if parent(s) cannot be reached: 1_____
Name/Relationship/Phone #

2_____
Name/Relationship/Phone #

In the event of a medical emergency, I authorize the school to obtain medical treatment for my child: Parent(s) signature: _____

I authorize my child to take Tylenol if needed: **Yes / No** (please circle)

Student's medical conditions/allergies: _____

Medications taken regularly: _____

Physician Name: _____ Phone #: _____

Please use the reverse side of this form for any other educational/medical/social-emotional information that you would like to share

Child's e-mail address: _____ (optional)

Child's Hebrew name: _____

Our child's name, address, and phone # can be distributed to the class. **Yes / No** (please circle)

Our child's photo can be included in publicity material **with / without** (please circle) the child being identified by name. **Yes / No** (please circle)

Parent(s) Signature: _____ _____

Date: _____