

# Congregation Shir Shalom Religious School

## HEALTH FORM

2015 - 2016

*This information will be seen only by the Religious School Director, office personnel, and appropriate teacher(s).*

Student's Name \_\_\_\_\_ Home Phone No. \_\_\_\_\_

Pediatrician Name and Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Cell Phone Number(s) \_\_\_\_\_

If parents are not available in an emergency, please notify: \_\_\_\_\_

Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Does your child receive any special services or have an IEP at his/her day school? Yes No (circle)

If yes, please explain \_\_\_\_\_

Does your child need any program modifications for success in his/her public/private school? Yes No (circle)

If yes, please explain \_\_\_\_\_

**Should your child receive any special instruction by our educational team?** Yes No (circle)

If yes, please explain (whatever information you can give us will be helpful) \_\_\_\_\_

**Does your child have any dietary restrictions/allergies? Drug allergies?** \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_

**Is your child currently on medication?** Yes No (circle)

If yes, name of medication \_\_\_\_\_

Dosage \_\_\_\_\_ How often/when \_\_\_\_\_

Will your child need to bring and/or take any medication while at Religious School? Yes No (circle)

If yes, please explain \_\_\_\_\_

*(For any child needing medication or special medical considerations on a regular basis while at Religious School, we will need a note of explanation from the child's physician in the office so that we can meet your child's needs.)*

The above information is correct to the best of my knowledge and I give my child permission to engage in all activities. I hereby authorize the calling in of a physician and/or the providing of other necessary medical services at my expense should an emergency arise.

\_\_\_\_\_  
Date \_\_\_\_\_

**Parent/Guardian Signature**