

Kol Ami Chai School
HEALTH CARE INFORMATION-CONFIDENTIAL

Child's Name: _____

Name of physician: _____ Phone Number: _____

Address: _____ City: _____

Insurance Provider: _____

Group ID #: _____ Member #: _____

Name of Dentist: _____ Phone Number: _____

Address: _____ City: _____

Dental Insurance: _____

Name of preferred hospital _____

In an event of a medical emergency, I authorize Congregation Kol Ami staff to obtain emergency medical treatment for my child. I understand that I will be contacted immediately.

Parent/Guardian Signature: _____ Date: _____

Printed Name of above signature: _____

1. Does your child have any medical allergies or chronic illness? (Please list)
2. Does your child take medications on a regular basis? If so, what medications and when?
3. Do you want someone in the administration to give your child medication during religious school?
4. Are there emergency medications the school should have available for your child? What are the indications that require administration of the medication? For Epi-Pens, please note who you like to administer the medication (child, teacher, etc.)

MEDICATION 1: _____

INDICATIONS: _____

MEDICATION 2: _____

INDICATION: _____

5. Are there other urgent medical situations which will likely/possibly arise? (Examples: diabetic shock, epileptic seizure, etc.) How should we treat your child in such circumstances?

PARENT SIGNATURE: _____ DATE: _____