

***Kol Emet Confirmation Retreat
Medical/Health/Contact Information Form***

Student Last Name _____ First Name _____ DOB _____

Health Insurance Information:

Insurance carrier _____

Name of subscriber _____

Policy _____ Group _____

In case of emergency, if parent cannot be reached, contact:

Name _____ Phone _____ Relationship to student _____

In case of emergency, which hospital would you like your child to be taken to? _____

Doctor's Name _____ Doctor's Phone _____

Dentist's Name _____ Dentist's Phone _____

List your student's known allergies (including food allergies):

List your student's prescription medications, dosages, and schedules:

Is there any additional information that the staff should know?

I hereby authorize the Kol Emet staff to authorize emergency medication treatment for my child if I cannot be reached at the time of a medical emergency.

Parent Signature _____ Date _____