KEHILLAT ISRAEL
RECONSTRUCTIONIST CONGREGATION
EARLY CHILDHOOD CENTER

Child Emergency Card

In case of an emergency, it is imperative that the school be able to reach the student's Parent (as defined below). Please fill in the information on both sides of this card carefully and accurately. Please use ink and print clearly.

Child's Name _____ ☐ Male _____
Last Name First Middle ☐ Female Class

_____ _____
Home Address City/Zip Home Phone Birthdate

_____Lives with: ☐ Mother ☐ Father ☐ Both Parents ☐ Other _____
Mailing Address, if different from above City/Zip Address change? ☐ No ☐ Yes If Yes, please contact the School Office.

_____|_____
Parent 1: Last Name First Email Employer

_____|_____|_____|_____
Home Address City/Zip Home Phone Work Phone Cell Phone

_____|_____
Parent 2: Last Name First Email Employer

_____ _____|_____|_____|_____
Home Address, City/Zip Home Phone Work Phone Cell Phone

NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PERSONS LISTED BELOW. In selecting someone to whom you authorize the release of your child, consider: Is this person prepared to handle any special medical needs required by your child?

I/we hereby authorize contact with, release of emergency related information, or release of the student to the following persons in the event of illness, injury, evacuation or other emergency that may occur while students are in school.

Name	Relationship	Home Phone	Cell Phone

Out-of-state contact: Name_____ Relationship_____

Home Phone_____ Cell Phone _____

I declare that the information on this form is true and correct. I will notify the school office immediately of any changes

Parent's Signature _____ **Date** _____

MEDICAL/HEALTH INFORMATION
Medication: Does your child take medication? Yes/No

Medication	Dosage	Hour(s) given

Medication Dosage Hour(s) given
If your child requires medication at school, all medication sent to school must be in the original prescription container with a current date and the child's name. **Also** a **"Medication/treatment Authorization"** form, must be completed and signed by the physician and the parent and must be on file.

Health Insurance Information: *Please check appropriate box.*

Physician/Health Care Provider_____ Phone No**.** _____

Health Plan/Group Name _____ Policy No. _____

Dentist _____Phone No**.** _____

Vision and/or Hearing Information:
□ Wears glasses/contacts: YES/NO □ Wears hearing aid(s) YES/NO

Medical Conditions: Please check the appropriate boxes if your child has any of the following:

□ Severe Allergies □ Food/Environmental □ Stinging Insects/Bees □ Medicines/Drugs

□ Other

Please explain: _____

Requiring: → □ Benadryl □ EpiPen Other _____

□ Asthma If checked, □ uses inhaler □ on daily medication

□ Seizures If checked, on medication? □ Yes □ No

□ Diabetes If checked insulin dependent? □ Yes □ No

□ Movement limitations: _____

□ Other (please explain): _____

□ Recent illness, hospitalization or surgery. If checked, please provide date(s) and description(s):
_____
_____

EMERGENCY TREATMENT AUTHORIZATION

I the undersigned parent(s) of

_____
do hereby give authorization and consent to the school to obtain emergency medical care and necessary emergency transportation to a healthcare facility.

_____ _____
Parent Signature Date

RELEASE OF MEDICAL INFORMATION

I hereby understand and authorize that my child's medical records or other medical information, furnished to the school, will be shared with school officials and emergency personnel who have a legitimate medical/educational purpose for accessing such medical records and information.

_____ _____
Parent Signature Date

Recent Photo of child:

ECC will provide photo