EL PASO JEWISH ACADEMY
STUDENT EMERGENCY INFORMATION
&
CONSENT FOR MEDICAL TREATMENT

Student's Last Name _______________ First Name _______________ Birth date _______________

Home Address _______________ Home Phone _______________

Mother's Name _______________ Work Phone/Cell Phone _______________

Father's Name _______________ Work Phone/Cell Phone _______________

Emergency Contact (Relative or Friend) _______________ Phone No. _______________

Emergency Contact (Relative or Friend) _______________ Phone No. _______________

Family Physician _______________ Phone No. _______________

Emergency Hospital _______________ Insurance/Medicaid # _______________ Military Sponsor # _______________

List medical problems your child has:

____

____

____

List medications your child is taking:

____

____

____

List allergies:

____

____

Name of doctor prescribing medications:

____

____

CONSENT FOR MEDICAL TREATMENT

I authorize an authority of the El Paso Jewish Academy to give consent to a physician and/or hospital for emergency medical and/or surgical treatment of my child for injuries/illness which require such treatment during school hours or after hours while attending school sponsored activities provided an authorized school representative is present.

I understand that an El Paso Jewish Academy Representative will not assume any financial responsibility for expense nor liability for decisions made for such treatment and that the school will notify us as soon as possible following the emergency, but in no way is treatment to be delayed until we have been notified.

I also authorize my child to participate in health services and screenings provided by the school.

_______________ Signature of Parent/Legal Guardian

_______________ Date