

UNITED HEBREW SCHOOLS  
EMERGENCY INFORMATION FORM

Parent [1] /Guardian's Full Name (and spouse/partner's name if different from parent 1)

Parent [2]/Guardian's Full Name (and spouse/partner's name if different from parent 2)

Address

Address (if different)

Parent/Guardian's Employer

Parent/Guardian's Employer

Home Phone

Work Phone

Cell Phone

Home Phone

Work Phone

Cell Phone

Email Address

Email Address

**Name of relative/friend/neighbor to be called in case of emergency when parents cannot be reached.**

Name and Relationship

Home Phone

Cell Phone

Name and Relationship

Home Phone

Cell Phone

Student's Name (Last, First, Middle Initial)

Student's Name (Last, First, Middle Initial)

\_\_\_/\_\_\_/\_\_\_  
Date of Birth

M/F  
Gender

\_\_\_/\_\_\_/\_\_\_  
Date of Birth

M/F  
Gender

Doctor

Phone

Doctor

Phone

Explain any unusual health conditions:

Explain any unusual health conditions:

Check if appropriate: \_\_Diabetes \_\_Heart \_\_Allergy \_\_Seizures \_\_Asthma

Check if appropriate: \_\_Diabetes \_\_Heart \_\_Allergy \_\_Seizures \_\_Asthma

Details: \_\_\_\_\_

Details: \_\_\_\_\_

List any serious illness during the past 12 months \_\_\_\_\_

List any serious illness during the past 12 months \_\_\_\_\_

Physical restrictions \_\_\_\_\_

Physical restrictions \_\_\_\_\_

If in the judgment of the school authorities, emergency treatment is required, I authorize my child(ren) to be transported by ambulance to a hospital for treatment. I also understand that the local ambulance service does reserve the right to convey the patient to the nearest definitive care hospital or the hospital of their choice, should they deem it necessary. I hereby authorize the physician(s) at the hospital to give emergency treatment to my child(ren).

Date \_\_\_\_\_

Signed, Parent or Legal Guardian \_\_\_\_\_