

צור קשר Tzor Keshet Academy 2011-2012

Medical & Personal Information Sheet

Student Name:		Student Name:		Student Name:	
School Grade (Sept. 2011):		School Grade (Sept. 2011):		School Grade (Sept. 2011):	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Birthdate:	Age as of Sept. 2011:	Birthdate:	Age as of Sept. 2011:	Birthdate:	Age as of Sept. 2011:
Does the child have any allergies or physical conditions that require special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain:		Does the child have any allergies or physical conditions that require special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain: If Yes, please explain:		Does the child have any allergies or physical conditions that require special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Address:	City:	Zip Code:	Home Phone:
1.			
2.			

If divorce or separated, do you want school business mailed to both parents? Yes No
If yes, please list the the additional mailing details on line 2 above.

Mother's Name:	Father's Name:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email Address:	Email Address:

Child lives with: Mother Father Both Parents Other (Please specify): _____

In an emergency, if I cannot be reached, please contact these individuals:

Name:	Relationship:	Phone Number:
1.		
2.		

Medical Insurance Company Name:	Policy Number:	Phone Number:

I give my child(ren) permission to attend all Tzor Keshet Academy activities. I understand Keneset Israel Torah Center arranges for the safely and chaperonage of my child(ren). I agree to hold harmless and indemnify Keneset Israel Torah Center, and the Orthodox Union from any and all claims or causers of action arising out of his or her participation in Tzork Keshet Academy activities.

In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by the Instructor/Chaperone to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child(ren) named above. Of course, in an emergency, every effort will be made to reach parents or their proxy.

I (parent) understand that my signature indicates acceptance of all parts of this form.

Signature of Parent or Guardian:	Date: