



Frankel Religious School Student Information Form

Please print clearly with black or blue ink only. Please complete both sides.

Student Data

Student's Name (First & Last) _____ Gender _____ Grade in Sept.2011 _____

Student's Hebrew Name _____ Birthdate _____

Parent #1 _____ Parent #2 _____

Parents' Address _____

City _____ Zip _____ Home Phone _____

Parent #2 Address (if different) _____

City _____ Zip _____ Home Phone _____

Student lives primarily with (circle one): Both Parents / Mother / Father / Guardian (Name) _____

Phones: Parent #1 _____ (work) _____ (cell) _____

Phones: Parent #2 _____ (work) _____ (cell) _____

E-Mail: Parent #1 _____ Parent #2 _____

Secular School / Day School _____

Emergency Contacts (other than Parents):

Local: Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Out of State: Name _____ Relationship _____ Phone _____

Name of person(s) with whom you carpool _____ Phone _____

Persons to Whom Child May Be Released

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Medical Conditions - Please check and explain below if your child has any of the following:

Allergies to food or medication Diabetes Attention Disorder (ADD/ADHD)

Allergies to environment or insects Asthma Other: _____

If you have checked one or more of the above, please describe: _____

Medication:

My child takes the following prescribed medication on a regular basis (indicate name, dosage, frequency):

_____ for treatment of _____

Instructions for administering medication in the event of an emergency: _____

All medications should be given to your child’s teacher in their original container with clearly written directions.

Special Needs:

In order for us to provide the best possible Jewish education for your child, it is critical for us to know of any behavioral, emotional, or learning issues that might have an impact on your child. Please contact the Religious school office to discuss ways in which we can help your child succeed, and keep us informed about new developments throughout the school year. This information will be kept confidential and only shared among the relevant teaching professionals.

My child succeeds best when you take the following needs into consideration: _____

Medical Insurance:

Occasionally, an emergency arises when it is necessary for a school representative to contact parents while their child is at school. Every effort will be made to notify the parents or someone designated by them in the event a child becomes very ill or is involved in a serious accident. If this cannot be done, the policy of the synagogue is to transport the child to the nearest emergency hospital. This action will be taken in all such cases, unless you provide written instructions to the contrary.

Child’s Physician _____ Physician’s Phone _____

Health Insurance Carrier _____ Policy Holder _____

Subscriber I.D. # _____ Group #, if applicable _____

I/We Authorize Consent on the Checked Information:

- Emergency transportation, treatment and / or hospitalization for my child, in the event I cannot be reached.
- Release of my child to any of the persons listed on the front page, indicated by an (*), in the event I cannot be reached.
- Administration of medication as prescribed by my child’s physician, in the event I cannot be reached.
- Administration of ibuprofen or acetaminophen to my child, if deemed appropriate, in the event I cannot be reached.
- Use of my child’s photograph in HNT’s written publications and on the HNT Website.
- My family members’ names, home phone, secular school, street & e-mail addresses to be included in class and/or school rosters.

Authorization of Consent to Treatment of a Minor:

I/We, the undersigned, parent(s) of _____, a minor, do hereby authorize the Education Director or agent for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is to be rendered under the general or special supervision of any licensed physician or surgeon on the medical staff of a licensed hospital, whether such an examination, diagnosis or treatment is rendered at the office of said physician or at such a hospital. It is understood that this authorization is given in advance of any specific examination, diagnosis or treatment or hospital care required, and is given to provide authority and power on the part of the Education Director or agent to give specific consent to any and all such examinations, diagnoses, treatments or hospital care which the afore-mentioned physician or surgeon may deem advisable in the exercise of his/her best judgment.

I/We further do hold and save Herzl-Ner Tamid and its entire staff harmless from any and all claims, bills, fees or charges of any nature whatsoever which may arise as a result of this authorization.

This authorization shall remain in effect for one year from the date below and will cover attendance at all school and synagogue functions, as well as all trips away from the synagogue for which the parent(s) have signed a trip consent form.

Please add any information that you feel we should know about your child.

Parent’s Signature _____ Date _____

Parent’s Signature _____ Date _____