The Polsky Religious School of Conservative Judaism
14200 Lamar Ave
Overland Park, KS 66223 913-647-7279

HEALTH FORM 2019/20

Student's name ____________________ Birth Date ____________________

Parent 1____________________ Parent 2____________________

Cell Number ____________________ Cell Number ____________________

Health Insurance company ____________________ Policy # ____________________

Name of policy holder ____________________ Ins. Co. Phone # (________) ____________________

Date of last Tetanus shot ____________________ **Child's weight** ________________ **lbs.**

Does your child currently have or ever been treated for:

________Surgery ________ Serious Illness ________ Hyperactivity ________ Frequent headaches

________ Allergies ________ Asthma ________ Seizures ________ Diabetes

Other ____________________

If you answered yes to any of the above, please explain:

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____

Current medication(s), dosage, & reason prescribed ____________________

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Name of physician ____________________ Telephone # ____________________

IN CASE OF AN EMERGENCY *(PARENTS WILL BE NOTIFIED FIRST),* PLEASE LIST EMERGENCY CONTACTS WE CAN REACH <u>BESIDE YOURSELVES</u> *(PLEASE CONTACT THE SCHOOL OFFICE IMMEDIATELY WITH ANY CHANGES):*

1)____________________ HOME PHONE____________________

RELATIONSHIP____________________ CELL PHONE # ____________________

2)____________________ HOME PHONE____________________

RELATIONSHIP____________________ CELL PHONE # ____________________

In order to optimize your child's learning environment, please identify any special services s/he receives in public school such as the gifted program, learning center, remedial reading, resource room, or IEP **(if your child has an IEP, PLEASE ATTACH A COPY TO THIS FORM)**.

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Parent/Guardian Signature ____________________

AUTHORIZATION TO PERMIT EMERGENCY MEDICAL CARE OR TREATMENT AND RELEASE OF INFORMATION FOR MEDIA AND OTHERWISE

To Whom It May Concern:

Effective from August 19, 2019 through May 5 2020; we ____

and ________________________________, the parents and/or legal guardians of __________________, do hereby grant Congregation Beth Shalom ("CBS"), its agents, servants, and employees, the authority to direct, authorize and permit any medical care or treatment for our child, ____________________________ ("Child") while in its care. We hereby agree to assume all financial responsibility for such care or treatment on behalf of our Child and to either pay the medical provider directly or to reimburse CBS, its agents, servants, and employees for any reasonable and necessary medical expenses incurred by it on behalf of our Child.

We also do hereby grant CBS, its agents, servants, and employees, the authority to remove our Child from its facilities while in its care in the event of any emergency which, in the sole and exclusive opinion of CBS, its agents, servants, and employees, necessitates such removal. We hereby agree that CBS, its agents, servants, and employees, may transport our Child to such other locations as may be deemed necessary in order to safeguard our Child from the known or perceived threats or risks to their safety.

Media

We also do hereby consent that any information or images relating to our Child may be reproduced by CBS and/or the public media for use in advertising, publicity, or educational activities including, but not limited to, CBS publications and/or videos, prints, television news and websites. Furthermore, we hereby consent that such images are the property of CBS and that CBS shall have the right to sell, duplicate, reproduce in the form of advertising, or otherwise publish and make other uses of such images as CBS may desire. We agree to waive any claims we may have and release CBS, its agents, servants, and employees, from any liabilities or claims arising out of such activities.

The Family Educational Rights and Privacy Act ("FERPA"), a federal law, requires that schools, with certain exceptions, obtain my written consent prior to disclosure of personally identifiable information from my Child's educational records. With this in mind, I agree that CBS may disclose appropriately designated "directory information" by my signature below. CBS has designated the following information as directory information: student's name, grade level, whether they are a student in good standing, and whether and when the student has graduated. A photocopy of this authorization shall be of the same force and effect as an original for purposes of authorizing and permitting the medical care or treatment requested for our Child.

Date: _______________________ **Signature** ____

Signature ____

****I would like the following contact information included on a PRS Family Roster that will be given to all PRS parents to be able to contact each other easily…(check all that apply)**

- ☐ **Name of Parent(s)**
- ☐ **Name of Student(s)**
- ☐ **Home Phone**
- ☐ **Cell Phone**
- ☐ **Email Address**
- ☐ **Do not include my information in the PRS Family Roster for 2019-2020**