



Temple Beth Or Religious School

Health Information 5771

A separate form is necessary for each child.

As part of our ongoing commitment to provide your child with the opportunity to reach his full potential, please complete the form below. Information is confidential. **Kindly return this form to the religious school office on or before the first day of school.**

Student's Name (print first and last) _____
Grade as of September 2010 _____ Circle: M or F
Family Name (if different than student's) _____
Phone _____ Email: _____

1. Does your child have an Individual Education Plan of any sort in public/private school?
____ Yes ____ No If yes, please attach a copy to this form.

2. Was a referral for assessment of concerns at school recently made or is one in progress? _____

3. Does your child receive support services in or out of the school day (special education/resource support, paraprofessional, one-on-one aide, private therapist, private tutor)? If so, please provide details. _____

4. Please check the appropriate box(es) that apply to your child:

- ADHD/ADD
- Allergies
- Anxiety
- Asperger's Syndrome
- Asthma
- Autism
- Cerebral Palsy
- Conduct/oppositional defiant Disorder
- Depression
- Developmental/Cognitive Delay
- Diabetes
- Dyslexia
- Emotional/Behavioral Disorder
- Epilepsy/Seizures
- Hearing Impairment
- Obsessive-Compulsive Disorder
- Physical Challenges
- Speech/Language Challenges
- Tourette's Syndrome
- Visual Impairment

Other _____

5. If your child has allergies, please list any specific allergies. How severe are these allergies? Instructions for teacher?

6. Does any information you provided above impact on your child's school performance? If yes, please provide details. Describe what we should do if your child is affected during religious school hours until you can be contacted.

7. Does your child take any medication? If so, please list:

The policy of Temple Beth Or Religious School is not to administer medication of any kind during school hours unless extenuating circumstances exist and special arrangements have been made with the Director of Lifelong Learning.

8. Is there any other information regarding your child's health or education that you would like to share?



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Family Emergency Information Form 2010-11 / 5771

Complete only one form per FAMILY

Family Name
Address
Town State Zip
Home Phone
Mother's Work phone Father's Work phone
Mother's Cell Father's Cell
Mother's Email Father's Email

Students' Names and Grades - please use both first and last names:

- 1. Grade
2. Grade
3. Grade

Doctor's Name
Doctor's Address (include town and zip)

Doctor's Phone

Insurance Company
Group Number
ID Policy Number

Emergency Contact

Sunday:
Name Phone
Tuesday or Thursday
Name Phone

I hereby give permission for my child to be taken off Temple grounds for the purpose of medical attention in the event that I cannot be contacted in an emergency. I authorize and designate Rabbi Ruth Zlotnick or the Director of Lifelong Learning, Irene Bolton, as my representative in the event of a medical emergency concerning my child.

I hereby give my permission to any physician or medical professional selected by the above representatives to hospitalize, treat, order injections, medication anesthesia or surgery for my child(ren) as may be medically required in the opinions of such medical professionals and in the event that I may not be able to be contacted in an emergency.

Parent Signature
Date