Congregation Shaar Hashalom
Religious School
Medical Release Form

Please, complete this page for each child enrolled in the Religious School

Student's Last Name: _____ First Name: _____

Home Phone: _____ **Hebrew Name:** _____

Date of Birth: ____/____/____ Grade: _____ Hebrew Level: _____

Student's Day School: _____

Student's e-mail: _____

Known Allergies: _____

Medical Conditions: _____

In the event of an emergency, I, _____
(please print)

(Relationship) _____
(please print)

authorize the representative of Congregation Shaar Hashalom to act on my behalf to approve such medical treatment including, without limitation, x-ray, examination, anesthetic, medical, dental, or surgical examination or treatment and general hospital care.

I SPECIFICALLY CERTIFY THAT:
This authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of Congregation Shaar Hashalom to give specific consent to any and all such examinations, treatment, or Hospital care.

The possession of the original of this Authorization by the congregation is evidence that the representative of Congregation Shaar Hashalom has care and control of such minor and that I cannot be contacted.
This Authorization shall remain effective for a period of one (1) year from its signing, unless sooner revoked by the physical destruction of the original hereof, such destruction being the only method of actual notice of the revocation of same.

I am the person having the power to consent to medical treatment of such minor, and assume the responsibility for the payment of such treatment
All blanks of this Authorization were filled in before I signed this Authorization.

Parent/Guardian Signature: **Date:**

_____ _____/_____/_____