



KOL HAVERIM

THE FINGER LAKES COMMUNITY FOR HUMANISTIC
JUDAISM
CULTURAL JEWISH SUNDAY SCHOOL

Medical Release Form 2009-10

Please complete a separate form for each child

Child's name: _____
FIRST MIDDLE LAST

Date of Birth: _____ Sex: male female

MEDICAL INFORMATION:

Family Physician/Address: _____ Telephone: _____

Have any condition now requiring medication? No Yes (If yes, please provide further information below)

Name of medication: _____ Dosage: _____

Is medication with them? Yes No If not, who will have it? _____

Allergies or reactions to any medication, food or other (please list): _____

Any restriction of activity for medical reasons? (If yes, please explain) _____

***Emergency Contact during Sunday School (cell phone or friend): _____

MEDICAL LIABILITY

I (we) the undersigned being the parent(s) or legal guardian(s) of the above named child, know that I may not be available to authorize medical, dental, surgical care and/or hospitalization for such child, and I wish to appoint someone to act in my absence and to give such authorization. This authorization is intended to give Kol Haverim Sunday School staff the right to give the consent for emergency diagnostic medical, dental, surgical procedures and hospitalization that the authorized person deems advisable, and which the physician, dentist, or hospital personnel in said person's judgment may deem advisable.

I have put the important medical facts, if any, on the top portion of this document. These medical facts are intended to assist medical personnel, or authorized person(s) in deciding what treatment is to be given. It is in no way intended to restrict the giving of authorization or consent by the person(s) named herein.

This authorization will be in effect during the class period of Sunday School.

It is intended that this document be presented to the physician, dentist, or appropriate hospital or medical personnel at such time that the medical, dental or surgical care or hospitalization shall be authorized.

It is intended that this authorization relieve the physician, dentist or person rendering such care, or the hospital or institution in which such care is given from any liability resulting from the failure of me(we), the parent(s) or guardian(s) of the above named child, from signing a consent or authorization to render such care. It is the intent that the person(s) appointed herein shall be able to act in my stead in making decisions.

Signed:

Parent or Guardian

Date

Parent or Guardian

Date