Last Name_____

The Emanuel Synagogue Religious School
Emergency Information Form, 2020/21 – 5781

Allergies: Please list any of your child(ren)'s allergies or sensitivities:

Student's Name(s)	Allergies and/or Sensitivities

If you will be sending medications to school, please complete the form on the reverse side.

To serve your child's needs, in the unlikely event of an emergency, please let us know any prescription medication(s) your child takes, the dosage, and reason. (All information will be kept confidential.)

Child's Name	Med/Dosage	Reason

Do your child(ren) have any physical restrictions? Please explain:

_____

Is there anything else you would like us to know about your child(ren)?

_____

Name, phone number and relationship to child(ren) of two people to be contacted in case of emergency when parents cannot be reached:

Name	Relationship	Number

In the unlikely event that your child should need medical attention and parents cannot be reached, please list:

Physician's Name and Phone_____
Hospital of Choice _____

Please be sure to discuss with your child(ren) any plan you and your family have in case Religious School should need to have an emergency early dismissal. Please sign below, after you have completed this form AND discussed Emergency plans with your child(ren).

Parent's signature _____Date_____

Last Name_____

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AUTHORIZATION FOR ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL AT THE EMANUEL SYNAGOGUE RELIGIOUS SCHOOL

The Connecticut State Law & Regulations require a physician's/dentist's written order and a parent or guardian's authorization for a nurse, principal or teacher to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of drug, strength, dosage, frequency, physician's/dentist's name and date of original prescription.

PHYSICIAN OR DENTIST'S ORDER

Name of Child _____Date_____

Address _____Date of Birth_____

Condition for which drug is being administered during school hours: _____

DRUG (name, dose, & method of administration): _____

Time of administration: _____

Medication shall be administered from: _____ to _____
(Date) (Date)

Relevant side effects & plan for their management: _____

Is this a controlled drug? _____ If yes, DEA number: _____

Physician's/Dentist's Name: _____Telephone: _____
(Type or print)

Address: _____

Physician's/Dentist's Signature: _____Date: _____

Nurse/Principal/Teacher: _____Date: _____

AUTHORIZATION BY PARENT/GUARDIAN for the administration of the above medication by school Personnel:

School Personnel: Date: _____

I hereby request that the above mediation, ordered by the physician/dentist for my child, _____, be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 45 school day supply of medication.
I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Name of Parent/Guardian: _____
(Type or print)

Signature: _____Relationship to child: _____

Address: _____Telephone: _____