

Medical Information for NTHC Religious School Student
5770 / 2009-2010

Student Name: _____

Physician's Name **and** Phone No.: _____

Clinic Name and Address: _____

Dentist's Name **and** Phone No.: _____

Clinic Name and Address: _____

Any Known Allergies: _____

What are signs of a reaction? _____

What are first steps to take? _____

Any Medical Problems: _____

Any Medications: _____

Consent for Medical Treatment

As the parent of _____, I hereby give consent to the North Tahoe Hebrew Congregation Religious School to obtain all emergency dental or medical care prescribed by a duly licensed physician (M.D.) or dentist (D.D.S.). This care may be given under whatever conditions are deemed necessary to preserve the life, limb or well being of my dependant. I understand that every effort will be made to contact me in such event.

Date: _____

Signature of Parent/ Legal Guardian

Mother's Cell Phone _____

Father's Cell Phone _____

Other contact person and cell phone: _____