FOR ECE STUDENTS ONLY - ONE PER CHILD

FOR MORE COPIES OR QUESTIONS EMAIL GABRIELLE AT GSAB@HILLELHEBREW.ORG

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Children's Residential Facilities

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Harkham Hillel Hebrew Academy
FACILITY NAME

TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____.
NAME

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )