



Medical Information Form

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Parent's Email: _____

Father's Cell: _____ Mother's Cell: _____

Emergency contact name and relationship: _____

Emergency contact phone number: _____

Name of Physician: _____ Phone: _____

Student's Medical Insurance Plan and ID number: _____

Please list any prescription medications: _____

Please list any health issues the Mesivta should be aware of: _____

Please list any allergies: _____

Please list any surgeries, serious illnesses or hospitalizations: _____

Any past or current psychologist, psychiatrist, or social worker consultations? Yes No

If yes, Name: _____ Phone: _____

Parental Permit:

- I herewith give authorities and faculty of Mesivta Shaarei Chaim my full consent to act in my behalf in the event of **any emergency** affecting my son. This includes but is not limited to diagnostic, therapeutic and/or operative procedures as may be deemed urgent and necessary by emergency medical personnel or a consulted healthcare professional, to be performed for my son.
- I hereby give permission, upon advice and at the discretion of Mesivta Shaarei Chaim staff, for my son to self-administer standard over-the-counter medication or first aid items, stocked by Mesivta Shaarei Chaim, as deemed necessary for non-urgent healthcare needs.

Student's name: _____

Parent's Signature: _____

Relationship: _____ Date: _____