



FOXMAN TORAH INSTITUTE

מתיבתא בית דוד

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The Joy of Torah - For Life

_____ School Year EMERGENCY INFORMATION FORM

Family Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Telephone _____

Email _____ Fax _____

Student Name	Date of Birth	Allergy to drugs/food	Medical problems, past or current	Names of current medications

Mother's Name _____ Business Phone _____ Fax _____

Cell Phone _____

Best E-mail (most frequently checked) _____

Father's Name _____ Business Phone _____ Fax _____

Cell Phone _____

Best E-mail (most frequently checked) _____

Physician's Name(s) _____ Telephone _____

Relative, (not parent), friend, or neighbor who may be contacted if parent cannot be reached:

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

ROUTINE CARE - I hereby give permission to Foxman Torah Institute aka Delaware Valley Torah Institute to administer first-aid care in emergency situations and to give my child(ren) Tylenol(acetaminophen), Ibuprofen, over-the-counter allergy medicine, and/or any other common household remedies when necessary.

I (parent or guardian), the undersigned, do hereby authorize FOXMAN TORAH INSTITUTE aka Delaware Valley Torah Institute as our general agent to any emergency care deemed advisable and to be rendered through general or specific supervision of any licensed physician or surgeon. It is understood that this authorization is given in advance of any specific need for treatment and is given to provide the authority to the aforesaid agent to give specific consent to any and all emergency treatment or hospital care which the physician in the exercise of his best judgment may deem advisable.

Signature of Parent

Date