

**Louis and Sarah Block Yeshiva High School  
Student Data & Emergency Information  
For Academic Year: 2009-10**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Father's Name: \_\_\_\_\_

(Title)

(First Name)

(Last Name)

Mother's Name: \_\_\_\_\_

(Title)

(First Name)

(Last Name)

Parents are:  Married  Divorced  Separated If parents are not married, which parent is responsible for student? \_\_\_\_\_

To whom shall school correspondence be sent? \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Mother's work #: \_\_\_\_\_ Father's work #: \_\_\_\_\_

Mother's cell phone: \_\_\_\_\_ Father's cell phone: \_\_\_\_\_

Pager #'s: \_\_\_\_\_ Email address: \_\_\_\_\_

If student is a dormer, Name of St. Louis host family: \_\_\_\_\_

Host Family Address: \_\_\_\_\_ Phone \_\_\_\_\_

**Emergency Information**

Best way to reach a parent in an emergency during the day: \_\_\_\_\_

**Student Information**

List significant medical conditions \_\_\_\_\_

Allergies \_\_\_\_\_

Current Medications \_\_\_\_\_

**Medical Care Providers**

Preferred Hospital \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist Name \_\_\_\_\_ Phone \_\_\_\_\_

Eye Care Specialist Name \_\_\_\_\_ Phone \_\_\_\_\_

Other Health Care Provider Name \_\_\_\_\_ Phone \_\_\_\_\_

**Insurance Information**

Provider \_\_\_\_\_ ID # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Additional Person(s) who might be contacted in the event parent/guardian cannot be reached:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Authorization for Emergency Care**

In case of emergency, I give my consent for the School to contact emergency medical services to attend to my child. I understand that the School will make every effort to contact me first to obtain specific consent for treatment. However, in the event that the School feels harm or injury is imminent and contacting a guardian is infeasible, I authorize the School to summon help and to provide to the attending medical technicians, physicians, hospital or clinic the relevant data judged necessary for treatment from my child's school records.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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**PARENTAL CONSENTS**

**Please initial the items for which you give consent and sign below.** In each case for which you sign, you agree that Louis and Sarah Block Yeshiva High School, and/or its employees, and/or BJC HealthCare members are not liable for any damage or injury that might occur during these activities, or in transit to or from them:

- \_\_\_\_\_ **1. Consent to Attend School Activities** – I hereby permit my child to attend any school-related outside activities, field trips, and other school functions, for the *current* school year of the Louis and Sarah Block Yeshiva High School, and to be transported to and/or from them by school employees, volunteers, or commercial vehicles.
- \_\_\_\_\_ **2. Consent to Drive Other Students** – I hereby permit my child to drive other students to and from the above-mentioned activities.
- \_\_\_\_\_ **3. Consent to Ride with Other Students** – I hereby permit my child to ride in cars driven by other students of the Louis and Sarah Block Yeshiva High School, as transportation to & from the above-mentioned activities.
- \_\_\_\_\_ **4. Consent to Leave School Grounds** – I hereby permit my child to leave school grounds during lunch and other free periods, **pending school approval.**
- \_\_\_\_\_ **5. Special Consent to Ride with Other Students** – I hereby permit my child to ride in cars driven by others when leaving in the manner described directly above.
- \_\_\_\_\_ **6. Protocol Medication Consent** – Specific medications have been approved for use with students as needed during the school day if parent/guardian consent is on file. These medications are available for use by designated school staff and include Acetaminophen, Bacitracin, Bactine, Hydrogen Peroxide, Dacriose & Baking Soda/meat tenderizer packs. I acknowledge that I have reviewed and am familiar with the Protocol Medication Policy and the Medication Policy. I realize a physician will not be present or available during the administration of medication, and that a non-medical person may administer medication. Further, I hold harmless BYHS employees from and against all claims arising out of the implementation of the Protocol Medication Policy & administration of medication under this policy and the Medication Policy.

Signature \_\_\_\_\_

Date \_\_\_\_\_

