



FOXMAN TORAH INSTITUTE

Stein Bais Medrash

Ezaicher Nishmas R' Avraham Zev ben R' Moshe HaKohen

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The Joy of Torah - For Life

EMERGENCY INFORMATION FORM

School Year 20__ - __

Family Name: _____ Date: _____

Address: _____

Home Telephone Number: _____

E-mail Address: _____ Fax: _____

Insurance Company Name: _____ Policy Number: _____

Please attach copy of student health insurance card (both sides of card please).

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: _____

Physician's Name: _____ 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