Congregation Or Ami | 26115 Mureau Road, Suite B | Calabasas, California 91302

Emergency and Medical Release Form

Please print neatly.

FAMILY (To speed data entry, please list male first, where applicable)

Family Name(s):	Adult 1 Name:	Adult 2 Name:
Address:	Office 1 Phone:	Office 2 Phone:
City, State, Zip:	Cell 1 Phone:	Cell 2 Phone:
Home Phone:	Email 1:	Email 2:

PART 1:
ADDITIONAL DRIVERS, aside from parents, authorized to pick up your student(s). (MUST be at least 18 years old)

Name:	Relationship to student:	Phone(s):
Name:	Relationship to student:	Phone(s):
Name:	Relationship to student:	Phone(s):

PART 2:
EARTHQUAKE EMERGENCY

Out-of-State or Out-of-Los Angeles/Ventura County Contact:

Although we hope never to experience another major earthquake, we must be prepared. Local phone services may be disrupted, while out-of-state or out-of-Los Angeles/Ventura calls may be possible. We require that every family establish an out-of-state or out of Los Angeles/Ventura County contact to act as a message center for your family in the event of a major earthquake.

REQUIRED: _____ ( ) _____ ( ) _____
Name of Contact Contact Telephone Number(s)

PART 3:
MEDICAL INFORMATION

Students' physician/medical practice: _____ Dr. Phone:_____

Insurance Carrier: _____ Subscriber Name _____

Group # _____ Subscriber (account) ID#_____

PLEASE CONTINUE ON OTHER SIDE

CHILD 1 Name:	*Does student have any special medical needs or require any special medical attention?* ☐ Yes ☐ No If yes, please describe:	*Allergies?* ☐ Yes ☐ No If yes, please describe in full:	*Is student taking any medications on a regular basis?* ☐ Yes ☐ No Name of medications/dosage:
CHILD 2 Name:	*Does student have any special medical needs or require any special medical attention?* ☐ Yes ☐ No If yes, please describe:	*Allergies?* ☐ Yes ☐ No If yes, please describe in full:	Is student taking any medications on a regular basis? ☐ Yes ☐ No Name of medications/dosage:
CHILD 3 Name:	*Does student have any special medical needs or require any special medical attention?* ☐ Yes ☐ No If yes, please describe:	*Allergies?* ☐ Yes ☐ No If yes, please describe in full:	*Is student taking any medications on a regular basis?* ☐ Yes ☐ No Name of medications/dosage:

PART 4:
REQUIRED: MEDICAL AUTHORIZATION/FIELD TRIP APPROVAL

In the event of an emergency or the sudden illness of my/our child(ren) occurring when I/we cannot be reached, I/we also give my/our consent for my/our child(ren) (list names) _____ to be treated by such emergency medical personnel, doctors and/or hospitals, as are selected by Congregation Or Ami. I/we understand that in the event of such emergency, Congregation Or Ami will make reasonable efforts to consult with the physician or medical group named above, but the nature of the emergency may require treatment be undertaken before such consultation is possible. In addition, I/we give my/our permission for Congregation Or Ami to take my aforementioned child(ren) on field trips, as scheduled by teachers or the Educational Staff.

REQUIRED: _____ _____
Signature of Consenting Parent/Guardian **Date**

PART 5:
SPECIAL NEEDS UPDATE (Please list applicable family members only)

Family member Name: Gender: M F ____	*Does your family member have any special learning, physical or emotional issues/needs?* ☐ Yes ☐ No *Does your child have an IEP?* ☐ Yes ☐ No	*Please describe:*
Family member Name: Gender: M F____	*Does your family member have any special learning, physical or emotional issues/needs?* ☐ Yes ☐ No *Does your child have an IEP?* ☐ Yes ☐ No	*Please describe:*