PARENTAL CONSENT FOR MEDICAL TREATMENT
IN THE EVENT OF AN EMERGENCY

Student Name:_____ **Date:** _____

I grant permission for my child _____ D.O.B._____to participate in youth education programs at Ahavath Achim as part of Chai Youth. My signature hereby releases and forever discharges Ahavath Achim Synagogue and its officers, trustees, employees, advisors, coordinators, chaperones, agents and their respective heirs at law, legal representatives, successors and assigns from any and all claims, demands, damages, actions, causes of action, suits and liabilities of every kind and nature, arising out of, resulting from, or relating to any incidents that may occur during these programs, including but not limited to any bodily injury to such child.

EMERGENCY AUTHORIZATION

As the Parent/Guardian of the child named above, I, (please print)_____, hereby give permission for the child to receive first aid, emergency medical transportation and emergency medical treatment (including x-ray examination, anesthetic, medical or surgical diagnosis) while in the care of Ahavath Achim Synagogue/Chai Youth and its' employees. I understand that I will be responsible for all costs incurred as a result of an emergency medical situation while my child is in the care of Ahavath Achim Synagogue/Chai Youth

If time permits a hospital choice to be made in an emergency, please name your hospital of choice:_____

Preferred Doctor's Name_____Phone #_____

EMERGENCY INFO:

Parent1/Guardian Name_____Relation_____Cell #_____

Parent 2/Guardian Name_____Relation_____Cell #_____

In the event I cannot be reached for an emergency, please contact:

Name_____Relation_____Cell #_____

INSURANCE INFO:

Company Name_____ID#_____Name of the Insured:_____

_____ By initialing here I acknowledge that all of the medical information I provided in the Ahavath Achim Synagogue/Chai Youth Registration form is complete, including medications, allergies, disorders, pre-existing medical conditions, etc.

*** Signature of Parent/Guardian** **Date**