



STUDENT INFORMATION UPDATE 2020 -2021
PLEASE FILL OUT TOP AND BOTTOM ON BOTH SIDES

Child's Name: _____ Class: _____

Home Address: _____

Parent's Information:

1st Parent's Name: _____ 2nd Parent's Name: _____

Primary Phone #: _____ Ok to text? Primary Phone #: _____ Ok to text?

E-mail: _____ E-mail: _____

Pick-up/ Release Authorization:

Name(s) and phone numbers(s) of person(s) who have permission to pick up your child from school:

1. _____ Relation: _____ Phone: _____
2. _____ Relation: _____ Phone: _____
3. _____ Relation: _____ Phone: _____
4. _____ Relation: _____ Phone: _____
5. _____ Relation: _____ Phone: _____



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Child's Name: _____ Class: _____

Home Address: _____ Home Phone: _____

Parent's Information:

1st Parent's Name: _____ 2nd Parent's Name: _____

Address: _____ Address: _____

Cell: _____ Cell: _____

Other Phone: _____ Other Phone: _____

E-mail: _____ E-mail: _____

Pick-up/ Release Authorization:

Name(s) and phone numbers(s) of person(s) who have permission to pick up your child from school:

1. _____ Relation: _____ Phone: _____
2. _____ Relation: _____ Phone: _____
3. _____ Relation: _____ Phone: _____
4. _____ Relation: _____ Phone: _____
5. _____ Relation: _____ Phone: _____

Emergency Contact (if parent or guardian is unavailable)

Name Relationship Best method of contact

Name Relationship Best method of contact

Medical Care Consent

In the event of an emergency involving my child, _____, and I cannot be reached, I give my consent for Temple Israel Early Childhood Learning Center to seek appropriate medical care, with the understanding that I will be notified as soon as possible of any such incident. In the event of a medical or surgical emergency, if I or my emergency contacts cannot be reached, I grant permission to the physician designated by Temple Israel Early Childhood Learning Center to hospitalize secure proper and necessary treatment for and order injections, anesthesia or surgery for my child, solely to the extent necessary until I can be reached.

Parent's Signature Date Parent's Signature Date

Medical Information

Allergies/Special Health Considerations Hospital Preference

Pediatrician Phone Address

Insurance Company Member ID Policy Holder

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