



MEDICAL INFORMATION

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Mount Sinai Academy

Emergency Contacts

If emergency contact information changes throughout the school year, please contact Ms. Carpenter to update your profile.

Parent 1

Name: _____ Phone: _____

Parent 2

Name: _____ Phone: _____

Emergency Contact

Name: _____ Phone: _____

Relationship to Student: _____

Additional Emergency Contact (*Optional*)

Name: _____ Phone: _____

Relationship to Student: _____

*Emergency contacts will be notified in the order they appear on the form.

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Medical Information

| Category | Information |
|--------------------|--------------------------------------|
| Allergies | |
| Medications | |
| Medical Conditions | |
| Physician | Name: Phone: |
| Insurance | Name: Address: Policy/Group #: |

*Please include a copy of your insurance card when you submit this document.

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Medical Waiver/Consent

Upon completion of your students emergency contact and medical information, please sign the medical waiver below.

I/We understand the nature of these classes and their activities. With such knowledge I/We voluntarily release the host church and the administrators of Mount Sinai Academy and their representatives, agents, employees, including teachers and parent helpers, from any and all liability related to the activities of this program. I/We understand that, in the event that medical attention is required, Mount Sinai Academy will make all reasonable efforts to contact me/us. However, if I/we cannot be contacted, I/we give my/our permission to Mount Sinai Academy to secure the services of a licensed physician to provide necessary treatment including anesthesia, surgery, medication, and intravenous (IV) therapy for my/our student.

Parent 1 Printed Name

Parent 1 Signature

Date

Parent 2 Printed Name

Parent 2 Signature

Date