TARBUT V'TORAH
Community Day School
Love Learning. Live Values. Discover Heritage.

MEDICAL INFORMATION

(To be filled out by a parent or guardian)

Today's Date_____
Child's Name_____ Home Phone (____)_____

Parent(s) Name(s) _____

Child's Date of Birth_____

Grade Applied_____

Does your child have any health problems about which the school should be aware? If so, please describe: _____
_____
_____

Does your child have any food or other allergies (plants, insects, etc.)? If so, please explain:
_____
_____
_____

Does your child take any medication for physical, emotional or behavioral needs on a regular basis? If yes, please list medication(s):
_____
_____

Has your child ever received occupational, vision or physical therapy? If yes, please explain:
_____
_____

Has your child ever been assessed by a private specialist or school personnel for any reason such as academic, speech and language, intelligence or behavioral performance? Yes_____ No_____
If yes, please explain and attach a copy of the evaluation report. _____
_____
_____

Has your child been diagnosed with any type of learning, emotional or behavioral disorder? If yes, please explain:
_____
_____
_____

Has there been a major event such as divorce, death or illness in the family, which might affect your child? If yes, please explain: _____
_____
_____

I (we) the undersigned parent, parents or legal guardian of the above-designated minor do hereby authorize Tarbut V'Torah Community Day School to the exchange and release of information with the medical professional(s) named below.

Name of Doctor _____ Office Phone _____
Name of Doctor _____ Office Phone _____
Parent Signature _____ Date _____