



**AUTHORIZATION AND RELEASE FOR EMERGENCY MEDICAL ATTENTION
2016-2017**

In the event that I (or those designated by me to act on my behalf) cannot be reached to make arrangements for emergency medical attention for my child _____, I authorize Cynthia Kirsch, and any person designated by her to act on behalf of the school to do so.

As such, Cynthia Kirsch and each such designee has my full consent to take my child to:

Dr. _____ Licensed Physician

Doctor's Address: _____

Doctor's Phone Number: _____

In the event of a medical emergency, Cynthia Kirsch and/or her designees have my full consent to take my child to the physician of her choice or can transport my child to the nearest emergency or hospital facility. That physician in charge, has my consent for any and all necessary treatment for my child when in his/her care. I hereby release the Beth Yeshurun Day School, Cynthia Kirsch, and each of her designees from any and all claims or causes of action arising out of the direction of my child to any physician or other emergency medical personnel in accordance with this Authorization and Release.

Parent's Signature

Parent Name (printed)

Child's Name

Child's Social Security Number

Date

Child's Grade