

# 2014-2015 She'arim/Gateways Emergency Medication Authorization



I give permission for my child(ren) \_\_\_\_\_ to participate in She'arim/Gateways, Mishkan Ha'am's innovative approach to Hebrew School. In the event of an accident or other medical emergency involving my child(ren), She'arim/Gateways should contact me at:

Parent(s) Name(s): \_\_\_\_\_

Telephone: \_\_\_\_\_ (home) \_\_\_\_\_ (home)  
\_\_\_\_\_ (cell) \_\_\_\_\_ (cell)  
\_\_\_\_\_ (business) \_\_\_\_\_ (business)  
\_\_\_\_\_ (email) \_\_\_\_\_ (email)

Name of workplace: \_\_\_\_\_

**If I cannot be reached, one of the following individuals should be contacted in the order listed:**

- 1) Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
2) Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Child(ren)'s Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**My child(ren) has/have the following allergies, food restrictions, or other health needs or conditions that require special care (continue on back if necessary):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I represent that I am the parent/legal guardian of the above-named child(ren).**

**If you cannot reach me or the individuals listed above, I authorize representatives of Mishkan Ha'am to act on my behalf to secure emergency medical treatment for my child(ren), and to arrange for emergency transportation to the nearest medical facility.**

Name of Parent/Legal Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_