



or shabbat

2009/10 MEDICAL CONSENT FORM

Dear Parent or Guardian

Whilst it is extremely unlikely that there will be a problem we feel it is prudent and necessary to have a completed medical consent form for all children attending *Or Shabbat* sessions when not accompanied by parents.

It would assist us if you could complete the form giving as much detail as possible, the form is a standard form and as such we do not expect all sections will be relevant to you. However where a section is relevant please use your best efforts to obtain the information requested. All information given will be treated as confidential.

Attached is a sheet giving medical authorisation if it had not been possible to make contact with your named emergency contact given on the form.

Additionally please include any medical condition(s) that we/I should be aware of e.g. diabetes, asthma.

Yours sincerely

Rabbi Rebecca Qassim Birk
Education Rabbi

Westminster Synagogue, Kent House, Rutland Gardens, Knightsbridge, London, SW7 1BX
Tel: 020 7584 3953; Fax: 020 7581 8012; email: secretary@westminstersynagogue.org; website:
www.westminstersynagogue.org

MEDICAL AUTHORISATION

Childs Full Name

I/We* being the legal Parent/Guardian* to the above name person do hereby authorise Rabbi Rebecca Qassim Birk or an authorised member of the *Or Shabbat* staff in my/our* absence to authorise required medical treatment on my/our* behalf by a qualified medical practitioner.

Relevant medical conditions

.....
.....

Signed Print Name

Dated.....

- *Delete as appropriate*
-

PLEASE COMPLETE ALL DETAILS WHEREVER POSSIBLE AND RETURN AS SOON AS POSSIBLE

CHILD'S DETAILS

First Name

Last Name

Address

Town

County

Post Code

Home Phone No. (.....).....

Mobile Phone No. (.....).....

Email address

Date of Birth

Parent/Guardian* Full Name(s)

Emergency Contact Number (.....).....

Emergency Contact Name

Relationship to Child