בס"ד

Division of Higher Learning
Associated Beth Rivkah Schools

310 Crown Street
Brooklyn, New York 11225
(718) 735-0400 Fax: (718) 735-0422

Student Health Declaration

Student's Name _____**Email Address** _____

Student's Home address _____

Student's Hebrew Name _____ **Mother's Hebrew Name** _____

Medical Insurance Information (Valid in New York) -_____

Do you have a Dor Yeshorim #? Yes _____ **No** _____

Do you have frequent headaches or migraines? _____

Do you have any allergies?_____ **If yes, please specify** _____

Do you have any eating limitations? _____ **If yes, please specify** _____

Do you take any medications? _____ **If yes, please specify** _____

Do you have or have a history of health issues or illnesses?_____

Did you ever need psychological of psychiatric attention? _____

Family Physician _____ **Phone#** _____ _____ _____

Emergency Contact _____ **Phone#** _____

Emergency Contact in Crown Heights _____**Phone#** _____

I hereby authorize Beth Rivkah to make all decisions concerning Emergency Medical Treatment

Student's Signature _____ **Cell #** _____

Parent's Signature _____ **Cell#** _____