



YESHIVA OF VIRGINIA

Main Office: 12285 Patterson Ave., Richmond, VA 23238
(804) 784-9050
(804) 784-9005 *fax*

AUTHORIZATION FOR MEDICAL TREATMENT

To Whom It May Concern,

I, _____ presently residing at _____

_____ Parent/Legal Guardian of the minor _____

residing in Richmond under the care of Yeshiva Faculty and attending Yeshiva of Virginia, do hereby authorize either the Principal or Representatives of Yeshiva of Virginia to act on my behalf in cases of emergency and to be informed of all medical conditions on behalf of the said minor's interest while a student at Yeshiva of Virginia.

SIGNED: _____ DATE: _____

Relationship to Student: _____

Parent / Legal Guardian Social Sec #: _____

Student Date of Birth: _____ Date of last Tetanus Shot: _____

Known Allergies: _____

(Please check one) I **DO** OR I **DO NOT** wish my son to take over-the-counter medications for pain/discomfort, fever, cough, congestion, skin rashes, cuts/abrasions, etc.

HEALTH INSURANCE INFORMATION:

Health Insurance Carrier Name: _____

Name of Subscriber: _____ Subscriber Date of Birth: _____

Identification #: _____ Group #: _____