EMERGENCY MEDICAL FORM

3575 Manchester Avenue • Cardiff by the Sea, CA 92007
Phone 760.436.0654 • Fax 760.436.2748

Student's name _____ Grade _____
LAST NAME FIRST NAME

Parent(s)/Guardian(s) Names_____Phone (____)_____ Cell (____)_____

IN THE EVENT OF AN EMERGENCY, WHEN I AM NOT AVAILABLE, PLEASE CONTACT

Name _____ Phone (____)_____ Cell (____)_____

Name _____ Phone (____)_____ Cell (____)_____

Attending Physician _____ Phone (____)_____

I hereby authorize Temple Solel to obtain necessary emergency care for my child. In the event of sudden illness, accident or injury which may occur while said minor is engaged in an activity supervised by Temple Solel representatives or employees, when neither the Parents, Guardians- or Family Physician can be contacted, I hereby give my consent pursuant to California Civil Code #25.8 for emergency treatment as shall be necessary under the circumstances by any physician licensed under the laws of the State of California.

Signed _____Date _____