

EMERGENCY MEDICAL FORM

TEMPLE SOLEL GUESTS

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]/Guardians' Names _____

Father's Contact Numbers: Home (____) _____ Cell (____) _____

Mother's Contact Numbers: Home (____) _____ 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, Guardian 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 _____

MEDICAL NEEDS

Does your child have any medical/emotional problems of which we should be aware? If yes, please explain: _____

Does your child have any allergies? Yes No If yes, explain: _____

Is your child on any regular medication? Yes No If yes, explain: _____

Does your child receive extra help outside the classroom at his/her secular school (i.e.: speech therapy, reading resource)? If yes, explain: _____