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____

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: ____________________

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

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

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

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