

**Southern California Yeshiva High School
Medical Consent/Emergency Contact Form
School Year 2008-2009**

STUDENT'S NAME _____ **GRADE** _____

AUTHORIZATION TO TREAT MINOR: In the event that I, or other parent/guardian, cannot be reached in an emergency, I hereby give permission to the school staff to secure proper treatment for my child. I do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services.

PARENT/GUARDIAN SECTION: MUST BE COMPLETED

Print Name(s) of Parent/Guardian: _____

Parent/Guardian Home Phone: _____

Parent/Guardian Work/Cell Phone: _____

Parent/Guardian Work/Cell Phone: _____

Emergency Contact Person: _____

Emergency Contact's Phone Number(s): _____

Pagers, cell phones, e-mail: _____

Primary Physician's Name: _____

Physician's Phone: _____

Dentist's Name: _____

Dentist's Phone: _____

Health Insurance Name: _____

Policy Number: _____

Health Insurance Phone: _____

Does student have any known Critical Medical Needs/Allergies/Conditions we should be aware of?: Yes No

If yes, please describe/list _____

I acknowledge that I have carefully read this document and understand the information therein. I agree to each of the terms and acknowledgments above.

Date: _____ **Parent /Guardian Signature:** _____