



Soille San Diego Hebrew Day School

Visiting Student Emergency Information

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This form must be completed and returned to SSDHDS admissions office prior to a school visit

Student's Name: _____

Date of Birth: _____ Current Grade: _____

Address: _____

Home Phone: _____

Father's Name: _____ Cell: _____

Address, if different than above: _____

Home Phone: _____ Business Phone: _____

Mother's Name: _____ Cell: _____

Address, if different than above: _____

Home Phone: _____ Business Phone: _____

Student resides with: Mother and Father Mother Father Guardian

Primary parent to contact in an emergency: _____ Cell: _____

Emergency contact when parent is unavailable:

Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Medical Insurance Carrier: _____ Policy #: _____

Allergies: _____

Medication: _____

Other Medical Information We Should Know: _____

Release:

In the event that a parent cannot be reached, I hereby give permission to the Soille San Diego Hebrew Day School to obtain emergency medical treatment for the above named child, including x-rays and to release information pertaining to my child's health record diagnosis, condition or health history, including any subsequent diagnosis which could supplement this form. This information may be released by a properly authorized representative of the school responsible for my child during periods of time when the school nurse is unavailable or, when the student is away from school (i.e. during field trips, sporting events). I agree that I am responsible for the cost of such medical treatment.

Parent Signature: _____ **Date:** _____

Soille San Diego Hebrew Day School has my permission to give acetaminophen with the discretion to the above named child, as designated in the SSDHDS Medical Standing Orders.

Parent Signature: _____ **Date:** _____

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