

TEMPLE BAT YAHM RELIGIOUS SCHOOL / TEMPLE BAT YAHM PRE-SCHOOL
1011 CAMELBACK STREET
NEWPORT BEACH, CA 92660
(949) 644-6563

(Please complete both sides of this form)

(I) (we), the undersigned, parents of (1) _____, (2) _____, (3) _____
(4) _____ minor(s) , do hereby authorize Temple Bat Yahm as agent(s) for the undersigned to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff or any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to (my) (our) above named agent(s) upon completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

These authorizations shall remain effective until _____ unless sooner revoked in writing delivered to said agent(s).

(Date)

(Parent)

(Legal Guardian)

Your baby-sitter or other authorized agent must be at least 18 years old to consent to emergency care for your child.

(Please complete the information following. It is only necessary to show names of children if more than one child is included on this form.)

Does your child/ren have an IEP?	Name _____	Yes__	No__
	Name _____	Yes__	No__
	Name _____	Yes__	No__
	Name _____	Yes__	No__

Medical conditions or limitations, including learning disabilities:

Name _____	Condition _____
Name _____	Condition _____
Name _____	Condition _____
Name _____	Condition _____

(Please use the other side of this form to indicate the nature of your child's/children's learning disability, if applicable, so that we may best accommodate his/her particular learning needs and what strategies work best in his/her school. We have found from experience that the more information we have, the more helpful we can be for each individual student.)

(Over)

(2)

Date of child's/children's last tetanus toxoid immunization: Name _____ Date _____
Name _____ Date _____
Name _____ Date _____
Name _____ Date _____

Allergies: Name _____ Allergy _____
Name _____ Allergy _____
Name _____ Allergy _____
Name _____ Allergy _____

Medications child/ren is/are currently taking: Name _____ Medication _____
Name _____ Medication _____
Name _____ Medication _____
Name _____ Medication _____

In the event of a major earthquake or other disaster, the school must have a 3-day supply of your child's/children's prescription medication or other necessary medication in order to maintain your child's/children's health and comfort. Your child's/children's registration will not be considered complete until this medication is provided to the school.

_____ Or _____
(Parent's Signature) (Legal Guardian)

Use space below to indicate any further information that may be helpful: