



TEMPLE MENORAH ROSENBERG SENIOR CENTER

REGISTRATION & EMERGENCY RELEASE INFORMATION

Name: _____ Birth Date: _____

Home Phone: () _____ Cell Phone: () _____

Email Address: _____

Address: _____

Spouse: _____

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, PLEASE CONTACT THE FOLLOWING PEOPLE:

Doctor: _____ Phone: () _____

Dentist: _____ Phone: () _____

Neighbor: _____ Phone: () _____

Relative: _____ Phone: () _____

SIGNATURE

DATE

Occasionally an emergency arises when it is necessary for a Temple representative to get in touch with the above-named people. Every effort will be made to notify them. If you should become very ill or be involved in a serious accident and this cannot be done, the policy of the Temple is to transport you to the nearest emergency hospital. This action will be taken in all such cases, unless instructions are provided to the contrary.

CONSENT FOR EMERGENCY MEDICAL TREATMENT

AS THE CLIENT or AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO TEMPLE MENORAH TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR _____ THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE INDIVIDUAL NAMED ABOVE.

CLIENT HAS THE FOLLOWING MEDICATION ALLERGIES:

Client/Authorized Representative/Conservator Signature
(CIRCLE APPROPRIATE TITLE)

Date