Tikvat Israel USY/Kadima Programs
2017-2018 Membership Form

____Kadima (Grades 6th-8th) $55 _____USY (Grades 9th-12th) $65

PLEASE PRINT

Child's Name _____ Age _____Sex: M / F

Address _____

City, State, Zip_____

Birthdate _____ Hebrew Name_____

Home Phone _____ Youth Cell Phone _____

Youth's email _____

Parent 1 Name:_____ Parent 1 Cell Phone:_____

Parent 1 Email:_____

Parent 2 Name:_____ Parent 2 Cell Phone:_____

Parent 2 Email:_____

Name of public/private school attending_____

Grade in public/private school _____

Member of TI: Yes No (circle one)

Do you belong to any other youth group (BBYO, Scouts, Habonim, etc.) _____

I give permission for my child's picture/image to be used in or on Youth Department brochures, flyers, websites, etc.: Yes No (circle one)

Please Return this Membership Form, Medical Form *(<u>on reverse</u>)* and Check to:

Tikvat Israel Youth, 2200 Baltimore Road, Rockville, MD 20851.

USY/Kadima Programs
2017-2018 Medical Form & Permission Slip

Every paid member of the Tikvat Israel Youth Department must have this form on file to insure his/her safety during synagogue sponsored programs.

I give my child,_____, permission to attend any and all programs and field trips sponsored by the Tikvat Israel Youth Department and its groups—Kadima and USY—during the 2017-2018 programming year. I understand and give my permission for my child to be transported by bus, staff or authorized parents. I understand that Kashrut will be observed at all activities.

I hereby release the Tikvat Israel Youth Department, Tikvat Israel Congregation and their employees and designated agents from any liabilities in case of accident or injuries. I understand that due caution, chaperonage and supervision will be provided by the Tikvat Israel Youth Department and its employees and agents.
IN THE EVENT THAT I CANNOT BE REACHED IN AN EMERGENCY, I GIVE PERMISSION FOR MY CHILD, NAMED BELOW, TO BE TREATED BY A PHYSICIAN OR HOSPITAL SELECTED BY THE STAFF IN CHARGE.

Child's name _____

Parent 1 name & home/cell/work phones _____

Parent 2 name & home/cell/work phones _____

Physician's name _____ Phone #_____

Insurance Co. _____Phone #_____ Plan #_____ Individual #_____

I will be sending the following medicines with my child(ren). *All medications must be in their original containers and must come with clear instructions on how and when to administer the medication.*

_____

Please list any medical or emotional problems that will help us in caring for your child, including allergies to foods, medicines, bee stings, etc. Use other side if needed.

_____

Please list the name(s) and phone number(s) of a close relative or friend who should be contacted in the event that the parents cannot be reached.

_____

Name Relationship Phone #

_____

Name Relationship Phone #

_____

Parent's Signature Date