

**Tikvat Israel USY/Kadima Programs
2018-2019 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: _____ High School Graduation Year (Anticipated): _____

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 (*on reverse*) and Check to:

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

**USY/Kadima Programs
2018-2019 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 #
------	--------------	---------

--	--	--

Parent's Signature	Date
--------------------	------