KOL HAVERIM SENIOR YOUTH GROUP
GRADE 9-12

Name of Participant: _________________________ Birthday: ______________

Address: ____

Phone # (home): ________________Email:_________________Parent's email:_____________

Age: ____ School:______________ Grade: _______________

Parent's Names & Cell Phone Numbers: ____

Emergency Contact Information:

Name: ________________ Phone #: __________________Relationship: _____________

Medical Information

Doctor's Name: ________________ Phone #: __________________

Insurance Company: ______________ Policy #:______________ Group #:__________

Does this participant have any allergies?____

Does this participant have any physical or emotional concerns of which the Temple Kol Haverim staff should be aware? If so, please describe:

____

Does this participant have any dietary restrictions? (kosher, vegetarian, gluten free, etc):

____

Restrictions on Activities: ________________________________

Medications to be taken overnight: _________________________________

I give permission to the staff members to dispense medications as needed. ❑ Yes ❑ No
My child may be given the following "over-the-counter" medications:
❑ Tylenol ❑Advil ❑Tums ❑Benadryl ❑Sudafed ❑Cough Drops ❑Other: __________

__My initials on this line confirm that I have paid the 2011-2012 GRSLY **membership fee of $20** (Please make your check out to GRSLY)

Parent Volunteer Information:

Parent support is crucial to the success of the youth program; please consider helping us in any of the following ways (check all that apply):
❑ Helping to transport participants to/from events ❑ Chaperoning events
❑ Making phone calls ❑ Helping with mailings