

GRSLY



קול הורם

KOL HAVERIM JUNIOR YOUTH GROUP  
GRADE 6-8

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