

**Congregation Kol Ami
YOUTH GROUP APPLICATION
KAUSY
2008-2009**

USY (Grade 9-12)
\$60 (\$80 Non-members)

Kadima (Grade 6-8)
\$50 (\$80 Non-members)

Boneem (Grade 3-5)
\$40 (\$80 Non-members)

10% Discount off 2nd Child's membership
All paid youth group members receive a chapter T-shirt
SIZE: Adult _____ Youth _____

Name _____
Last Middle First

*(Please enter the address you would like youth group information mailed to.
If there is more than one address, please enter a second address on the next line.)*

Address _____
Street City Zip

2nd Address _____
Street City Zip

Home Phone _____ Additional Phone _____

Age _____ Date of Birth ____/____/____ Grade _____ School _____

Youth Member's Email _____ Youth Member's Phone _____

Mother's Name _____ Email Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

Father's Name _____ Email Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

When was/will be your Bar/Bat Mitzvah? ____/____/____

Can you read Hebrew? Yes ____ No ____

Which services can you lead?

(Please circle)

- Shacharit
 - Mincha/Ma'ariv
 - Friday Night
-
- Musaf
 - Torah
 - Birkat Hamazon

EMERGENCY CONTACT INFORMATION:

Name _____

Relationship to Child _____ Phone # _____

I/We _____ hereby give permission for my son/daughter _____ to participate in programs sponsored by Congregation Kol Ami.

I am interested in assisting with the following to support the Youth Programs:

(Please circle)

- Chaperoning
- Driving
- Cooking
- Phone Calls
- Other _____

I would like to get flyers and information through my email. Yes ____ No ____

Email Address _____

Youth Email Address _____

Parent Signature _____

Paid: Yes ____ No ____ (Amount ____)

Cash ____ Check # ____ Credit Card ____

Siblings	Boneem	Kadima	USY

MEDICAL RELEASE FORM FOR A MINOR

Minor's Name _____ Date of Birth _____

Parent/Guardian's Name _____

Home Address _____ City _____ State ____ Zip Code _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Insurance Provider _____ Policy # _____

Address _____

Notify in Emergency (if other than parent or guardian) _____

Relationship _____ Phone _____

Family Physician _____ Phone _____

Allergies _____ Last Tetanus ____/____/____

Medicines currently being used

Dosage/Frequency

Current overall health _____

AUTHORIZATION FOR TREATMENT OF MINOR

We, the undersigned, parent or legal guardian of _____, a minor, do hereby consent authorized medical personnel to perform routine tests and treatment for the health of my child. In the event that we cannot be reached in an emergency, we hereby give permission for an authorized physician to hospitalize, secure proper treatments, and to order injection, anesthesia, or surgery for my child as named above.

(Parent/Guardian Signature & Date)

(Parent/Guardian Signature & Date)

