Or Register Online at:
templebethorr.org/youth-group-registration-form/

Temple Beth Orr
2151 Riverside Drive, Coral Springs, FL 33071
Phone: 954.753.3232 ● Fax: 954.753.2559
Website: www.templebethorr.org
5777 ● Youth Group Registration Form ● 2017/2018
Youth Director, Scott London, slondon@templebethorr.org

	Grades 3, 4, & 5	Grades 6 & 7	Grade 8	Grades 9 -12
Please Circle One:	**Chaverim**	**Jr. BOATY**	**Jr. BOATY**	**BOATY**
***Temple Member**	$0 included w/tuition	$0 Included w/tuition	$200	$230
***Non -Member**	$200	$250	$250	$280

***Registration form must be completed in order to be considered a member of Youth Group.**

Youth Information:

Last name: _____ First name: _____ Middle: _____

Date of Birth: _____/_____/_____ Gender: □ Male □ Female

Mailing Address: _____

City, State, Zip: _____

Home Phone: _(_____)_____-_____ Youth Cell phone: _(_____)_____-_____

Youth email: _____@_____ T-Shirt Size: (Child) □S □ M □L (Adult) □ S □M □L □XL

Grade in September 2017: _____ Name of secular school: _____

Temple Member: □Yes □No

Involved with Jewish Youth/Jewish Camp? Which Youth Group/Jewish Camp: _____

Guardian Information:

Guardian 1
Marital Status: □married □single □divorced □separated

Name: _____
(last) (first) (title)

Work phone: _(_____)_____-_____

Home phone: _(_____)_____-_____

Cell phone: _(_____)_____-_____

Email: _____@_____

Occupation: _____

Address (if different than student address):

Guardian 2
Marital Status: □married □single □divorced □separated

Name: _____
(last) (first) (title)

Work phone: _(_____)_____-_____

Home phone: _(_____)_____-_____

Cell phone: _(_____)_____-_____

Email: _____@_____

Occupation: _____

Address (if different than student address):

(turn over)

MEDICAL INFORMATION & RELEASE FORM:

Understanding your child's medical, physical, or psychological needs will help our staff secure your child's safety, well-being, and productivity. Please indicate the applicable conditions below and elaborate as needed.

Please list current medication with dosage your child is taking:

Medical Concern		Medication/Dosage	Medical Concern		Medication/Dosage
□	ADD		□	ADHD	
□	Asthma		□	Learning Disabled	
□	Perceptual Problems		□	Diabetes	
□	Epilepsy		□	Hearing Loss	
□	Visual Problems		□	Speech Problems	
□	Emotional Disturbances		□	Allergies	
□	Other (Please Specify):		□	Other (Please Specify):	

Is there any other information that you would like to share with us to help us provide your child with the most rewarding experience (please print)? _____

_____

GUARDIAN RELEASE

I hereby give permission for my child, _____, to participate in the 2017-2018 Youth Department program at Temple Beth Orr, on both Regional and Sub-Regional Levels. As the parent/guardian of above minor child I do by hereby release, forever discharge and hold harmless Temple Beth Orr and the advisors, chaperones, and volunteers from any and all liability, claims, or demands for personal injury, sickness or death, as well as property damage and expenses. This release covers meetings on Temple Beth Orr property or any other site during programs and activities.

_____ I give my permission to allow my child to travel by bus to chapter/sub regional and regional events. This release covers transportation and/or drivers provided by Temple Beth Orr and its representatives who are properly licensed to drive in the state of Florida.

_____ I give permission for my child's photograph/video to be taken during youth group activities and have the photograph/video used for display within the synagogue, on our website, in press releases or advertisements. The Youth Department requests respectfully your permission to photograph your child/children and will make every effort to honor your wishes when such occasions arise.

_____ I understand that this wavier will be the predominant permission slip for the year for my child unless another slip is required.

**In the event of an emergency, surgical or otherwise, if I cannot be reached, I hereby give permission for my child to be transported to the nearest medical facility and specifically authorize the representative of Temple Beth Orr to select a physician and/or authorize medical treatment, including hospitalization, anesthesia, injection, surgery, or other measures which he/she feels are in the best interest of my child.

Signature: _____ Date (MM/DD/YY): _____

Emergency Contact Information (Other than Parents):

Name (Please Print): _____ Phone: (____)_____-_____

Relationship (Please Print): _____

Name of Child's Physician (Emergency Only): _____

Telephone # of Child's Physician (Emergency Only): _____

Insurance Carrier Name (Please Print): _____

Insurance Policy Number: _____