



TEMPLE SINAI

Junior Youth Group

Temple Sinai's Middle School Youth Group
Grades 5-7

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 Number: _____

Does this participant have any allergies? _____

Does this participant have any physical or emotional concerns of which the Temple Sinai 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 2010-2011 Junior Youth Group membership fee of \$18

Parent Volunteer Information:

Parental support is crucial to the success of the youth program; please consider helping us in any of the following ways (check all that apply):

____ Serving on the Youth Committee _____ Helping to transport participants to/from events

____ Chaperoning events _____ Making Phone Calls _____ helping w/ mailings