



**OHEV SHALOM Kadima Youth Group (3rd through 7th grades) Enrollment Form**

Please fill out this form and mail OR drop off a check for \$45 PER CHILD payable to Congregation Ohev Shalom, 2 Chester Road, Wallingford, PA 19086. **Attn: Kadima Youth** in Memo. This one-time fee covers costs and food for 6 events (see accompanying flier with 2011-2012 schedule). Scholarships are available upon request.

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Child's e-mail: \_\_\_\_\_ Family e-mail: \_\_\_\_\_

Name(s) of additional child/ren in household (if applicable):

\_\_\_\_\_ Birthday: \_\_\_\_\_ Grade: \_\_\_\_\_

\_\_\_\_\_ Birthday: \_\_\_\_\_ Grade: \_\_\_\_\_

**Permission to Participate and Medical Release**

I consent and give permission for my child, \_\_\_\_\_ to attend and participate in all planned trips and activities arranged by Ohev Shalom Youth Group (Kadima). I certify that my child is physically able to participate in all such activities. In case of emergency, I authorize you, as my agent and at my sole cost and expense, to engage in appropriate healthcare providers to administer, prescribe, and/or direct the administration of any medication, other medical treatment, care, surgery, hospitalization, or medical procedures and services deemed appropriate under the circumstances, if you are not able to timely contact me for instructions.

Medical Insurer and Policy #: \_\_\_\_\_

***Emergency Contact Info:***

(1) Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #'s: \_\_\_\_\_

(2) Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #'s: \_\_\_\_\_

Any medical conditions or food, medical, or other allergies we should be aware of:

\_\_\_\_\_  
\_\_\_\_\_