CONGREGATION NER TAMID OF SOUTH BAY
USY and KADIMA REGISTRATION FORM 2019-2020

Membership Dues*:

KADIMA	**4-6th Grade**	**$110/CNT Member**	**$138/Non-CNT Member**
USY	**7-12 Grade**	**$122/CNT Member**	**$160/Non-CNT Member**

Please note that KADIMA & USY membership dues are separate from CLAL & USY High tuition.

FAMILY NAME _____

PLEASE ATTACH A PHOTOGRAPH FOR EACH CHILD

CHILD'S NAME	GRADE/PROGRAM	BIRTHDAY

Parent/Guardian _____Phone # _____

Home Address _____
Street & Number City, State & Zip

Emergency Contact _____Phone # _____

Parent E-Mail Address _____

Children's E-Mail Address _____

List any allergies – food, drugs, plants, insects, etc. _____

PHOTO RELEASE

If you do **NOT** authorize Congregation Ner Tamid to use photos of your child(ren) in print and online media, please check here: ☐

_____ _____ _____
Signature of Parent /Guardian Relationship to Student Date

Date of last Tetanus booster _____

MEDICAL INSURANCE

Insurance Co. _____

Policy Number _____

Physician Name _____Phone # _____

ALL OF THE INFORMATION ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THE IMPORTANCE OF KEEPING THIS INFORMATION ACCURATE AND AGREE TO CONTACT THE YOUTH OFFICE IF THERE IS ANY CHANGE IN HIS/HER MEDICAL CONDITION.

_____ _____
Parent/Guardian Signature Date

PLEASE TURN OVER – MEDICAL RELEASE ON BACK

USY FIELD TRIPS
AUTHORIZATION: CONSENT TO TREAT A MINOR

I/WE, the undersigned parent(s)/guardian(s) of

_____

Name of Student

a minor, do hereby give permission to my child to participate in all Congregation Ner Tamid Kadima/USY programs, activities and events and do release Congregation Ner Tamid and its representatives from liability arising out of my child's participation in such activities.

In addition, **I/WE**, the undersigned parent/guardian of the above child, do further certify that my child is physically able to participate in such activity and hereby authorize Congregation Ner Tamid and its authorized representatives as agents for the undersigned, to consent to any x-ray examination, anesthetic, medical and/or surgical diagnosis or treatment and hospital care which is to be rendered under the general or specific supervision of any licensed physician (under the provision of the California medicine practice act) or the staff of a licensed hospital, whether such diagnosis, examination or treatment is rendered at the office of said physician, or at such hospital.

It is understood that this authorization is given in advance of any specific examination, diagnosis, treatment or hospital care being required, and is given to provide authority and power on the part of our above-named agents to give specific consent to any and all such examinations, diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

I/WE hereby authorize any hospital which has provided to the above-named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to my (our) above-named agent(s) upon the completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

I/WE also understand that my child is obliged to conform to the Youth Department Code of Conduct and I/We understand that failure to comply with the code will serve as a basis for ejection from the group without refund.

I/WE HAVE READ AND FULLY AGREE TO THE MEDICAL LIABILITY FORM ABOVE:

_____ _____

Parent or Guardian Signature Only Date

PLEASE COMPLETE OTHER SIDE