

SHAGY Membership Form

Name _____ Age _____ Grade _____

Address _____ Birthday _____

City, State, Zip _____ Cell Phone # _____

E-mail Address _____

Your High School _____ City _____

Parent 1 Name _____ Parent 2 Name _____

Parent 1 Cell # _____ Parent 2 Cell # _____

Home Phone # _____ Other Phone _____

Parent 1 Email _____ Parent 2 Email _____

My parents both live at the address listed above

Other Address(es) _____

Membership Dues

Cong. Shir Hadash Members:

___ \$36 Chai

___ \$50 Mitzvah

___ \$100 Macher

Non-Shir Hadash Member Rate:

___ \$72 Double Chai

___ \$100 Macher

Membership dues include \$18 for Central West Region Regional dues.

Make checks payable to Cong. Shir Hadash. Return this form to the Temple Office.

Thank you for your support!!

Date: _____ Check #: _____ \$ Amt: _____

Health & Emergency Information

All information is required and will be kept confidential

Emergency Contact Info:

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____
Medical Insurance Carrier: _____ Policy # _____
Doctor's Name: _____ Phone # _____
Dentist's Name: _____ Phone # _____

Please describe any physical and/or emotional conditions the SHAGY advisor should be aware of: _____

Please list any medications that your child takes:

List any allergies: _____

Does your child have asthma? _____ If yes, please describe the nature of the problem and necessary treatments. _____

Optional Authorization (choose one):

_____ If my child requests, it is OK to dispense the following over-the-counter meds:

Tylenol Advil Sudafed Other _____

_____ Do not dispense any over-the-counter meds to my child, even if s/he requests.

Parental Medical Release

I agree not to hold Congregation Shir Hadash liable for accident, loss or theft that may occur during the course of an event. In the event that I cannot be reached in an emergency, I hereby grant permission to the physician selected by the Advisor/Chaperone to hospitalize, secure necessary treatment or anesthesia for my child, _____. I have indicated any pertinent medical information on this form, including all medications currently being taken by my child. My signature below indicates that I agree to the terms and conditions of this form.

Parent's Name (please print) _____

Parent Signature _____ Date _____