Family Name: ___________

Congregation Tikvat Jacob 2011-12

Congregation Tikvat Jacob

3rd-12th Grade Religious School Retreat Release Form

November 4 – 6, 2011 (3rd-6th grade) or May 4- 6, 2012 (7th-12th grade)

Name of Participant: ________________________ Age: _______ Grade: ______

Name(s) of Parent(s)/Guardian(s): ____

Home Phone #: __________________ Cell/Pager # __________________________

Emergency Contact and Phone: ____

Medical Insurance Company: ____

Policy Number: ______________________ Allergies: ________________________

I hereby give my permission for my child to participate in CTJ's Conclave Religious School Retreat at Camp Shalom in Malibu. Activities at Camp Shalom will include, among other things, rope course activities, crafts, archery and hiking. I understand that all Camp Shalom activities will be supervised by hired Camp Shalom staff.

I also release Congregation Tikvat Jacob and its representatives from all liability arising out of my child's participation in such activity.

In addition, I, 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 CTJ and its authorized representatives as agents for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital services which is/are to be rendered under the general or specific supervision of any licensed physician (under the provisions of the California Medicine Practice Act) or the staff of a licensed hospital, whether such a diagnosis, examination or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any such activity 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 best judgment may deem advisable.

The Authorization is given pursuant to the provisions of § 6910 of the Family Code of California.

I have read and fully agree to the medical/liability form above:

Parent/Guardian Signature: __________________________ Date: _______________

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Congregation Tikvat Jacob

Please Select :
☐ 3rd-6th – November 4 - 6
☐ 7th-12th May 4 – 6

SHALOM INSTITUTE: CAMP AND CONFERENCE CENTER

34342 Mulholland Hwy. , Malibu , CA 90265

SHALOM RETREAT CENTER
INFORMATION AND AUTHORIZATION FORM

STUDENT INFORMATION

Student's Name:	( ) Male ( ) Female	Birth date (MM/DD/YY)	Age as of 09/01/11:	Current Grade:
Street Address:	City:		State:	Zip:
Email Address: ____				

PARENT INFORMATION

Parent #1 Name:	Parent #1 Email:	Parent #1 Pager:
Parent #1 Home Phone: ( )	Parent #1 Work Phone: ( )	Parent #1 Cell Phone: ( )
Parent #2 Name:	Parent #2 Email:	Parent #2 Pager:
Parent #2 Home Phone: ( )	Parent #2 Work Phone: ( )	Parent #2 Cell Phone: ( )
Student lives with: ( ) Both Parents ( ) Mother ( ) Father ( ) Other:		

IN CASE OF EMERGENCY, IF PARENTS ARE UNAVAILABLE, PLEASE CONTACT:

Name ____ Home: ____ Work: ____

BUNKMATE REQUESTS (We will try our best to honor all requests.)

1.	2.	3.

MEDICAL INFORMATION

PLEASE INDICATE ANY ALLERGIES, SPECIFIC MEDICAL CONCERNS, AND/OR DIETARY RESTRICTIONS:

____

____

PLEASE LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING:

1. MEDICATION: ____ DOSAGE: ____ FREQUENCY: ____
2. MEDICATION: ____ DOSAGE: ____ FREQUENCY: ____
3. MEDICATION: ____ DOSAGE: ____ FREQUENCY: ____

MEDICAL INSURANCE COMPANY ____

INSURANCE POLICY NUMBER ____

PHYSICIAN TO BE CONTACTED IN CASE OF EMERGENCY ____

PHYSICIAN'S PHONE NUMBER ____

ADDITIONAL INFORMATION

Is there any other information you think might be useful to us? (Special needs, behavioral issues, etc.)

____

____

USE ADDITIONAL SPACE ON REVERSE SIDE IF NECESSARY

PLEASE FILL OUT REVERSE SIDE

ADDITIONAL INFORMATION (Continued from other side):

____

____

____

SHALOM RETREAT CENTER TERMS OF REGISTRATION & PARENT AUTHORIZATION

1. Shalom Institute may use any photograph, slide, video or likeness of my child for camp publicity or other publications associated with the camp..
2. Shalom Institute accepts no responsibility for loss or damage to any student's property during the retreat.
3. At the discretion of the camp director, my child may be sent home because of behavioral problems, the bringing of alcohol, drugs, and/or cigarettes to camp.
4. I agree to have our name, address, e-mail, and phone number listed on a retreat roster to be distributed to all families.
5. I give my child permission to participate in all the activities during the retreat, including ropes course and hikes.
6. Shalom Institute has my permission to provide routine non-surgical medical care. In the event of a medical emergency and I cannot be reached, I hereby give permission to the Physician selected by the Camp Director or his agent, to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child as named herein.
7. I understand that I am responsible for costs incurred on behalf of my child relating to accident or illness when treated outside of camp. I authorize payment of medical benefits to physician or supplier for services rendered while my child is at Shalom Institute.
8. (I) / (We), the undersigned, parent(s) of ______________________, a minor, do hereby authorize the Director of the Shalom Institute, or his/her authorized representative, as agent(s) for the undersigned, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the California Medicine Practice Act on the medical staff of a licensed hospital, whether such examination, diagnosis or treatment is rendered at the office of said physician or at such a hospital.
9. 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 agent(s) to give specific consent to any and all such examinations, diagnoses, treatments or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. This authorization is give pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until the Shalom Institute receives written notification from you canceling this consent form.
10. I ______________________ (Parent's Name) will indemnify, save harmless and defend: Jewish Federation Council of Greater Los Angeles, its officers, directors, agents, and employees, the Shalom Institute, its officers, directors, agents, and employees from all liability from loss, damage, or injury to persons or property in any manner arising out of or incident to the performance of this agreement including without limitation all consequential damages and/or attorney's fees.

I certify that all of the information on this application is true and accurate. I have read and agreed to the above Shalom Institute Terms of Registration and Parent Authorization.

______________________________ Parent/Guardian Signature

Date of Application _____/_____/_____

☐ Please add us to the Shalom Institute mailing list. We would love more information on Shalom Institute year-round programs.