

## Rosh Hodesh: *It's a Girl Thing!*

### Registration Form

**Please complete both sides & return to:**

Kehilla Community Synagogue, Rosh Hodesh, 1300 Grand Ave, Piedmont, CA 94610  
Please include payment to "Kehilla Community Synagogue" \$225 – members; \$325 non-members

Questions? Contact Elizheva Hurvich, rosh@kehillasynagogue.org or 510-547-2424 x104.

Name (of teen) \_\_\_\_\_ Hebrew name \_\_\_\_\_ Birth date \_\_\_\_\_

Girl's email address \_\_\_\_\_ (please print clearly)

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

Mailing address \_\_\_\_\_

City \_\_\_\_\_ Zip code \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ (best to call Hm Cell)

Parents' names 1. \_\_\_\_\_ 2. \_\_\_\_\_

Parents' address(es), if different from girl's

1. \_\_\_\_\_

2. \_\_\_\_\_

Parents' email address(es) PLEASE PRINT CLEARLY!

1. \_\_\_\_\_

2. \_\_\_\_\_

Parents' cell phone number(s)

1. \_\_\_\_\_ 2. \_\_\_\_\_

Aternate Emergency Contact: \_\_\_\_\_ phone: \_\_\_\_\_

**For teen participant to complete:**

**I am interested in participating in *Rosh Hodesh! It's A Girl Thing* because...**

**I am looking forward to...**

**I hope to get out of it...**

**I am nervous or concerned that...**

(please turn over & complete the other side, too!)

**We have no medical personnel onsite, however our staff will be CPR certified. We use 911 for emergencies (paramedics). In the event you cannot be reached, your signature authorizes Kehilla staff to obtain necessary medical aid, including ambulance service.**

**If your daughter takes any regular medication and/or has any food or medication allergies, list here:**

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**Girl's full name:** \_\_\_\_\_

**Girl's insurance carrier:** \_\_\_\_\_

**Policy number** \_\_\_\_\_

**Doctor** \_\_\_\_\_

**Phone number** \_\_\_\_\_

**Authorization to Consent to Treatment of a Minor**

I hereby authorize the Kehilla Community Synagogue/representative to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment or hospital care that is deemed advisable by, and is to be rendered under the supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act or to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment or hospital care that is deemed advisable by, and is to be rendered under the supervision of any dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, hospital, or otherwise.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of said agent(s) to give specific consent to any and all such diagnosis, treatment and hospital care that such physician or dentist in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Family Code Section 6550-6552 of California and shall remain effective until revoked. It is understood that every effort will be made by Kehilla Community Synagogue/School to contact me before exercising this authorization.

I hereby authorize Kehilla Community Synagogue staff to engage for my child \_\_\_\_\_ (*her name*) at my expense any necessary emergency medical or dental care, until I can be informed and make further arrangements. I hereby incorporate by reference the "Authorization to Consent to Treatment of a Minor" as set forth above. This authorization will expire on June 30, 2008.

PRINT Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_