







Youth Group Visitor Agreement 2020-2021

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 **TOUCHY**
(Temple Dor Dorim)
 **ATID**
 **@TOUCHY_TDD**
 **@ATID_TDD**
 **@TOUCHY_TDD**

ATID (6-8th) **TOUCHY (9-12th)**

Participant's Name:		Grade as of Aug. 2020:	
Email of Participant:		Date of Birth:	
Home Address:			
City:	Zip:	Cell # of Participant:	
Participant Enjoys:			

MEDICAL INFORMATION: Please list any/all allergies participant has and any/all medical information of which the Youth Director should be aware. **If there are no known allergies, please indicate that as NKA.**

Our family is a member of Temple Dor Dorim: Yes No
Please call the Temple if you would like to learn more about our TDD family.

Parent 1	Parent 2
Name:	Name:
Cell #:	Cell #:
Home #:	Home #:
Work #:	Work #:
Email:	Email:
Parents are: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Other	
Participant lives with:	

* Information regarding upcoming events will be sent via e-mail.*

Emergency Information	
Emergency Contact (other than parent):	
Relationship to Participant:	Emergency Phone #:
Physician Name:	Physician Phone #:
Insurance Name:	Policy/Plan #:
Insurance Phone #:	Group #:

Please see reverse side!

Authorizations/Permissions:

General: As parent/guardian of my child, I grant permission for my child to participate in all Temple Dor Dorim Youth Programming for the 2020-2021 year. I hereby release Temple Dor Dorim and its staff of any and all liabilities incident to and arising out of any/all Youth Department programs.

Publicity Release: As parent/guardian of my child, I grant permission for Temple Dor Dorim to use my child's likeness or photograph in any publication, advertisement, display, or other medium in connection with the programs, activities, and events of Temple Dor Dorim.

with name without name

RSVPs: I understand that space at an event is contingent upon on timely RSVPs and that RSVPs will be considered binding for payment.

Immunization Certification: As parent/guardian of my child, I confirm that _____ has completed the age-appropriate vaccine schedule recommended by the Florida Department of Health.

Medical/Surgical: As parent/guardian of my child, in the event that I cannot be reached in an emergency, I give express permission for Temple Dor Dorim to secure proper medical treatment for my child at a hospital or with a physician selected by Temple Dor Dorim. I hereby grant express permission to the physician or hospital selected by the temple to hospitalize, treat, order injection or anesthesia, or perform surgery for my child. Furthermore, I accept full responsibility for any such services rendered.

Parent/Guardian's Signature:	Date:
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Youth Scholarship Fund

The Youth Scholarship Fund allows the youth of Temple Dor Dorim to be even more deeply involved in programs locally, throughout the country, and in Israel.

We would like to make a donation to the **Rabbi Norman & Shoshi Lipson Youth Scholarship Fund.**

\$ 360 \$ 180 \$ 100 \$ 54 \$ 36 \$ 18 Other: \$ _____

Payment Information	Amount Due:
Credit Card #:	Exp. Date:
<input type="checkbox"/> American Express <input type="checkbox"/> Discover <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa	Check #: Payable to Temple Dor Dorim
I agree to have my credit card charged as indicated above. Signature of Cardholder:	Today's Date: