

TEMPLE CHAVERIM
WAIVER AND RELEASE

In consideration of Temple Chaverim of Long Island (the "Temple") accepting the application of the participant identified below (the "Participant") to participate in one or more of Temple Chaverim's Youth Programs (the "Program"), the undersigned parents, custodial parent or guardians of the Participant, for the undersigned and the Participant, and their respective heirs, successors, executors, administrators and assigns, waive and release any and all claims for damages for death, personal injury or loss of property which the undersigned or the Participant may have as a result of the Participant's participation in the Program and hereby discharge and release Temple Chaverim of Long Island (the "Temple") and its trustees, officers, employees and members, including members who assist in administering the Program (the "Temple Parties"), from all liability arising out of or connected in any way with the Participant's participation in a Program, unless resulting from the gross negligence or willful misconduct of any of the Temple Parties. Since participation in a Program is voluntary, the undersigned and the Participant voluntarily assume all risks of loss, damage or injury that may be sustained while participating in the Program, including risk of serious injury.

The Temple may (directly by its employees or through third parties) administer first aid or other emergency medical services, and the same shall not be construed as an admission of liability to the undersigned or the Participant, and does not affect the foregoing waiver and release of the Temple Parties.

Each parent, custodian parent or guardian of the Participant must sign below.

Print Name

Date

Print Name

Date

Name of Participant: _____

TEMPLE CHAVERIM

AUTHORIZATION FOR EMERGENCY MEDICAL - SURGICAL TREATMENT

LAST NAME _____ FIRST NAME _____
DATE OF BIRTH _____ SEX _____ AGE _____
ADDRESS _____ TOWN&STATE _____ ZIP _____
HOME PHONE NUMBER _____
PARENTS' BUSINESS PHONE: FATHER _____ MOTHER _____
EMERGENCY NAME _____ EMERGENCY PHONE# _____
FAMILY PHYSICIAN NAME /TELEPHONE# _____
HOSPITAL/MEDICAL INSURANCE COMPANY _____
POLICY NUMBER# _____

HEALTH HISTORY: (Check - give approximate dates)

Frequent Colds _____ Ear Infections _____ Fainting _____ German Measles _____ T.B. _____
Chicken Pox _____ Mumps _____ Athlete's Foot _____ Bronchitis _____ Polio _____
Stomach Upsets _____ Sinusitis _____ Convulsions _____ Rheumatic Fever _____ Poison Ivy _____
Motion Sickness _____ Whooping Cough _____ Diabetes _____ Heart Trouble _____ Measles _____
Operations or Serious Illness or Injury. Please Explain _____
Allergic Reactions (bee stings, medications, etc.) _____
Food Allergies _____ Other Allergies _____
Does the child have Asthma? _____ What medication is used, and how often is it administered? _____
Does your child take any medication on a regular basis? _____ ***If yes, what medication is taken? (Please attach a doctor's note)**
Has your daughter menstruated? _____ If not, has it been discussed with her? _____

AUTHORIZATION FOR EMERGENCY MEDICAL - SURGICAL TREATMENT

NOTE: It is the firm hope that the authorization granted on this form will never have to be used. However, for the safety of your child, sound medical practice calls for such authorization. In emergency situations wherein, for some reason the parent cannot be contacted immediately, this form may be extremely important. Doctors and hospitals refuse to give any treatment, regardless of how minor, unless they have a notarized authorization from a parent.

THE AUTHORIZATION GRANTED BY THIS FORM WILL BE USED ONLY WHEN NECESSARY AND ONLY AFTER EVERY REASONABLE ATTEMPT HAS BEEN MADE TO CONTACT A PARENT OR GUARDIAN.

I understand that in the event I cannot be reached, I hereby consent to and authorize the physician or hospital selected by the Temple Chaverim of Long Island or its agents to hospitalize, secure proper treatment for, to order injection, anesthesia, surgery and any preliminary, further or additional treatments, or procedures, tests, etc. that may be in the judgment of the doctor and/or hospital advisable or necessary at the time, for my child, as named below:

DATED: _____, 20____ CHILD'SNAME _____

I CONSENT TO THE ABOVE: _____ RELATIONSHIP _____
SIGNATURE OF PARENT/GUARDIAN

STATE OF NEW YORK
COUNTY OF _____

On the _____ day of _____, 2____ before me, the undersigned, personally appeared _____ to me known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), or the person upon behalf of which the individual(s) acted, executed the instrument.

NOTARY PUBLIC