

Adat Elohim, Ahavat  
Shalom, Temple Akiba,  
Beth Shir Shalom

Religious School Retreat  
February 24-26, 2023

## SHALOM INSTITUTE

### CAMP AND CONFERENCE CENTER

at Camp Alonim, 1101 Pepper Tree Ln, Simi Valley, CA 93064



## INFORMATION AND AUTHORIZATION FORM

### STUDENT INFORMATION

Student's Name:	( ) Male ( ) Female	Birth date (MM/DD/YY)	Age as of 09/01/22:	Current Grade:
Street Address:	City:	State:	Zip:	
Email Address: -----				

### PARENT INFORMATION

Parent #1 Name:	Parent #1 Email:	Parent #1 Cell Phone: ( )
Parent #1 Home Phone: ( )	Parent #1 Work Phone: ( )	
Parent #2 Name:	Parent #2 Email:	Parent #2 Cell Phone: ( )
Parent #2 Home Phone: ( )	Parent #2 Work 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.
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### 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 -----

**PLEASE FILL OUT REVERSE SIDE**

## ADDITIONAL INFORMATION

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

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### SHALOM RETREAT CENTER TERMS OF REGISTRATION & PARENT AUTHORIZATION

1. Shalom Institute may use any photograph, slide, or likeness of my child for camp publicity.
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.

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Parent Signature

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Date

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