



# 2012 Shabbaton Birthright Experience Application



## March 2 - 4, 2012

### At Camp Mountain Chai

JEWISH FEDERATION

**Open to all students in Grades 3 through 9**  
**SPONSORED BY THE JEWISH FEDERATION**

JEWISH FEDERATION

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*Tzedek Tzedek Tirdof – Justice, justice shall you pursue*

### CAMPER INFORMATION *PLEASE WRITE LEGIBLY*

Child's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_  Male  Female

Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Child's Synagogue or Day School: \_\_\_\_\_

#### Payment Options

Please select one of the payment options below:

**Option 1**  \$185

**Option 2**  \$100 & 4hrs. Community Service

What organization will participant perform his/her Community Service? \_\_\_\_\_

<b>Parent 1</b>	Home Phone:	E-mail:
Name:	Cell Phone:	
<b>Parent 2</b>	Home Phone:	E-mail:
Name:	Cell Phone:	
Camper lives with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____		

IN AN EMERGENCY, IF PARENTS ARE UNREACHABLE, PLEASE CALL:

\_\_\_\_\_  
Name Relationship to Student ( ) Telephone #

#### FRIEND REQUEST FOR CABINS – Only 2 please. We will try our best!

(We will try to honor at least one, but this may be difficult if requested roommate is not in the same grade)

1. _____	2. _____
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Will this be your child's first weekend away from home?  Yes  No

Has your child received severe disciplinary action (i.e. suspension or expulsion) from regular school, Jewish school, or camp setting?  Yes  No

*If yes, please explain:*

\_\_\_\_\_

Has your child undergone any sort of psychological counseling or psychotherapy?  Yes  No

For your child's benefit, is there anything that we need to know that will assist us during the Shabbaton?

\_\_\_\_\_

## SHABBATON MEDICAL FORM

Is your child allergic to any food, drug or environment?  Yes  No

If yes, please specify including item, reaction and treatment \_\_\_\_\_

Does your child have any medical condition that may impact their camp experience (i.e. asthma, bedwetting, recent illness, injury, surgery, etc.)  Yes  No

If yes, please describe \_\_\_\_\_

Is your child free of any communicable illness (immunizations up to date, no recent exposure or symptoms?)  Yes  No

Date of last tetanus vaccine \_\_\_\_\_

Medical insurance carrier \_\_\_\_\_ Policy# \_\_\_\_\_

### **PRESCRIPTION MEDICATIONS**

Please list medications your child takes routinely:

<u>Medication</u>	<u>Dosage</u>	<u>Reason for Medication</u>	<u>Will Medication be sent to camp?</u>	
1) _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No
2) _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No
3) _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No

### **NON-PRESCRIPTION MEDICATIONS\***

All prescription and non-prescription medications will be stored with and administered by the camp nurse. The nurse may have a limited supply of acetaminophen, ibuprofen, diphenhydramine (*Benedryl*), cough drops/syrup, and/or antacids. Please initial here if you give permission to the camp nurse to administer non-prescription medications to your child, in the appropriate circumstance.

Please initial \_\_\_\_\_

***\*YOUR CHILD WILL NOT BE GIVEN NON-PRESCRIPTION MEDICATIONS WITHOUT YOUR INITIALS ON THIS FORM.***

- I release Jewish Federation & my child's school from all responsibilities other than housing, meals and supervised camp activities.
- I consent to minor first aid and administration of medication for my child under the supervision of the camp nurse.
- The undersigned consents to the use of the camper's name, photograph, or other identification in connection with the Jewish Federation's programs, exchanges or publicity.
- In the event I cannot be reached in an emergency, it is my intention that the Directors be treated as acting *in loco parentis* for my child \_\_\_\_\_. I consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the California Medical 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 hospital.
- If I selected payment option 2, in lieu of financial payment, I understand that I have pledged that my child will perform 4 hours of community service for a synagogue, Jewish religious school, Jewish Day School, or other Jewish institution of our choice.

Parent's Name \_\_\_\_\_

Parent's Signature \_\_\_\_\_

Date: \_\_\_\_\_