



JEWISH FEDERATION

2012 Jewish Federation Youth Symphony Orchestra Registration Form



JEWISH FEDERATION

**Open to all children 8-15, with a minimum of 2 years of music instruction
SPONSORED BY THE JEWISH FEDERATION**

550 S. Second Avenue, Arcadia, CA 91006
Phone 626.445.0810 • Fax 626.445.5977 • E-mail federation@jewishsgpv.org

PARTICIPANT INFORMATION

Name: _____

Birth Date: _____ Male Female

Age: _____ Grade: _____

Address: _____ City: _____ Zip: _____

Child's Synagogue or Day School: _____

Instrument: _____ Number of years playing: _____

Payment Information

The cost for this program is \$180 and includes all music and other materials

Scholarships, payment plan, and multiple children discounts available

The payment can be paid by check (made payable to the Jewish Federation) or by Visa/Mastercard.

Parent 1	Home Phone:	E-mail:
Name:	Cell Phone:	
Parent 2	Home Phone:	E-mail:
Name:	Cell Phone:	
Participant 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 #

- I release Jewish Federation from all responsibilities other than rehearsal space and supervised youth orchestra-related activities.
- The undersigned consents to the use of the participant'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.

Parent's Name _____

Parent's Signature _____

Date: _____