



# CAUSY Registration Form

USYers' Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
School: \_\_\_\_\_ Graduation Year: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Gender: Male / Female

Parent 1: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Work: \_\_\_\_\_  
Address: \_\_\_\_\_  
Emergency Contact 1: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Work: \_\_\_\_\_  
Cell: \_\_\_\_\_

Parent 2: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Work: \_\_\_\_\_  
Address: \_\_\_\_\_  
Emergency Contact 2: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Work: \_\_\_\_\_  
Cell: \_\_\_\_\_

In the event your child becomes ill or injured while at a Youth Group function, a reasonable attempt will be made to (1) contact a parent, guardian or in the absence, (2) contact a relative or friend listed above, (3) take or dispatch student to the nearest hospital emergency room. I (we) give consent to have the above procedure followed for my child if Youth Department staff feel that it is necessary and I (we) further consent that my child receive hospital care and treatment as the physician or hospital may find necessary.

Signature of Parent(s) or Guardian: \_\_\_\_\_ Date \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Medical Insurance Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_

I hereby authorize Chizuk Amuno Congregation to use pictures of my child(ren) taken at CAC events in publicity and marketing for the school and youth program. I understand that my child's full name will NEVER appear next to his or her picture and the pictures will only be used to promote CAC and RRS. \_\_\_\_\_

INITIAL ABOVE

Please return the completed forms with a check to:  
Chizuk Amuno Congregation  
Isaac Woloff  
8100 Stevenson Rd  
Baltimore, MD 21208