Temple Israel/Temple Concord Hebrew School Registration Form for 2018-2019

Student's Full Name _____ Date of Birth_____

Hebrew Name _____

Public School _____ Grade _____

Parent/Guardian 1

Name: _____

Home Address_____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail _____

Parent/Guardian 2

Name: _____

Home Address_____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail _____

Our school is committed to providing a Jewish education, so each child can achieve the best of his or her ability. Please help us by providing the following information about your child. All information will be kept confidential.
Are there any important educational or medical needs we should know about your child? (allergies, asthma, medication taken regularly, reading, speech, communication, vision, hearing, motor problems, etc.)
_____

_____

□ I agree □ I do not agree that my child may be photographed for promotional pieces such as newspaper articles, calendars, and brochures.

Parent's/Guardian's Name_____ Signature _____ Date_____

Tuition charges are:

Sundays only $300 / Sundays and Tuesdays $650

MEDICAL EMERGENCY TREATMENT AUTHORIZATION

Person(s) to be contacted in case of emergency if parents or guardians **cannot** be reached:

Name: _____Phone # _____

Name: _____Phone # _____

Child's Physician_____Phone # _____

Child's Dentist _____Phone # _____

Hospital Preference _____ Date of Last Tetanus _____

Are there restrictions for medical care?

_____

_____

_____

I understand that if (child's name) _____ should ever need emergency medical treatment due to an accident, illness or any other reason, that every effort will be made to contact me, but if I am unavailable, and the persons identified above cannot be reached, I hereby authorize the Principal or Rabbi of Temple Concord or Temple Israel Religious School to secure emergency treatment for my child. I further consent to the medical treatment rendered by (preferred physician's name and phone #

_____) or in the event the designated physician is not available, by another licensed physician.

Name of Insurance Carrier _____Policy Number _____

Name of primary insured _____

Signature of Parent or Guardian _____Date _____