

2015-2016



For Office Use Only

Date Received _____

Grade/Class _____

Parents' Information

Parent #1

Parent #2

Name: _____

Name: _____

H: Phone: _____

H: Phone: _____

W: Phone: _____

W: Phone: _____

C: Phone: _____

C: Phone: _____

E-mail: _____

E-mail: _____

★ INCASE OF AN EMERGENCY PLEASE CHECK WHAT IS THE BEST NUMBER TO REACH YOU ★

Address at which children reside:

If you would like religious school materials sent to a parent with whom the children are not living, please fill out the following:

Name of Parent (Only if residence is different from student): _____

Address: _____ Zip: _____

H: Phone: _____ W: Phone: _____ C: Phone: _____

___ Check here if you do not wish to have you and your child's name, phone number, address and email included in our school directory, which will be given to each child.

If you only want some information included, please tell us what to include:

Students' Information

(Please fill out information for each child (Pre K–12th grade), whom you are enrolling)

Child # 1 __ Boy __ Girl

First _____ Middle _____ Last _____

Hebrew Name (if known) _____

Student's Date of Birth (DD/MM/YY) ____/____/____ Age as of Sept 1, 2015 _____

Student's E-mail Address _____

Student's cell phone __ (____) ____ - _____ Secular School Grade in Sept 2013 _____

Summer Camp Student Attended (if any):

Child # 2 __ Boy __ Girl

First _____ Middle _____ Last _____

Hebrew Name (if known) _____

Student's Date of Birth (DD/MM/YY) ____/____/____ Age as of Sept 1, 2015 _____

Student's E-mail Address _____

Student's cell phone __ (____) ____ - _____ Secular School Grade in Sept 2015 _____

Summer Camp Student Attended (if any):

Use additional pages as needed.

Students' Names and Grades:

(Please fill this out for all children being registered for religious school.)

Child's Name	Grade	Child's Name	Grade

Please help us get to know your children by answering the following questions about them and you. This information will be kept in strictest confidence and will only be used for classroom placement and to make informed decisions regarding your children's educational experiences. You may contact Rabbi Shafir Lobb to discuss any of the information on this form or any other educational concerns you may have at 520-247-4741.

1. Please tell us a little bit about religious practice in your home.
2. Do any of your children have chronic medical conditions? Please describe.
3. Do any of your children have any difficulties with hearing or vision? How can we accommodate these difficulties?
4. Do your children have any allergies to foods, medications, insects or other substances?*
5. Do your children experience any reading or language difficulties that might affect his/her performance or enjoyment of the Religious School? Please be as specific as possible.
6. Are any of your children receiving any special education services in secular school? If so, please describe.
7. Is there any specific information about your child(ren) that you would like us to know? *(Please use back for additional information)*

To My Knowledge (select one of the following)

- My child(ren) is able to fully participate in all School activities, including those which involve physical exertion.
- My child(ren) has a physical condition which may impose a degree of restriction on certain School activities. (Please indicate the nature of the condition and the restrictions.)

Parent Signature

- If your child has any food allergies (see #4), we will be sending an Allergy Action Plan form so that we can respond properly.

Students' Emergency Medical Form

Child's Name	DOB	Child's Name	DOB

In case of injury or illness of a child, every effort will be made to contact the parent or guardian. The following instructions will remain in force unless revoked by parent or guardian.

If injury or illness of minor, give child(ren) first aid? Yes No

If injury is serious and parents cannot be contacted, do you wish your personal physician or dentist contacted? Yes No

Name of Physician Address _____ Phone (____) _____ - _____

Name of Dentist Address _____ Phone (____) _____ - _____

Medical Insurance Company _____ Policy Number: _____

My child is allergic to the following medications: _____

Date of last tetanus shot: _____

Other relevant information: _____

In the event of a medical emergency, I authorize the staff to obtain emergency medical or dental treatment for my child/children. I understand that I will be contacted immediately, as will my child's physician.

In case of accident or serious illness, if the School is unable after reasonable effort to contact me, I hereby authorize the School to consult with or take my child for medical treatment to the physician indicated above. If there is difficulty in reaching this physician, the School may consult with or take my child to another or to an emergency medical facility or to the neighbor or relative listed below. I further authorize School personnel to apply such first aid as they deem necessary and appropriate.

I agree to pay all expenses incurred in the emergency care of my child.

If you cannot be reached in case of emergency, give the name of the person(s) to be notified.

1. Name _____ Phone: (____) _____ - _____

Address _____

2. Name _____ Phone: (____) _____ - _____

Address _____

3. Name _____ Phone: (____) _____ - _____

Address _____

Parent's Name (please print) Parent's Signature Date