



BETH EL SYNAGOGUE RELIGIOUS SCHOOL & HEBREW HIGH SCHOOL
 50 Maple Stream Road, East Windsor, NJ 08520, 609-443-4454, fax: 609-443-2887



REGISTRATION & EMERGENCY INFORMATION FORM 2018-2019/5779

In order to facilitate planning for the forthcoming school year, please submit one (1) registration form per student. Registration forms received **on or before May 31, 2018** must be accompanied by a **\$25.00 registration fee**. Registration forms received **after May 31, 2018** require a **\$40.00 registration fee**. Registration fees up to \$25 will be applied towards tuition.

Name of Student _____ Hebrew Name (if known) _____

Birthdate of Student _____ Hebrew Birthdate (if known) _____

Secular Grade of Student entering in the Fall _____ Hebrew Grade of Student entering in the Fall (if known) _____

Name(s) of parent(s)/guardian(s) _____

Student lives with (check one): ___ Both Parents ___ Father only ___ Mother only ___ Guardian

Home address (where mail is sent regarding student) _____

City _____ State _____ Zip Code _____

Mother/Guardian information:

Home phone # _____ Cell phone # _____ Work phone # _____
 Employer _____ Mother's email: _____

Father/Guardian information:

Home phone # _____ Cell phone # _____ Work phone # _____
 Employer _____ Father's email: _____

Other children (and grades) attending Beth El Religious School:

Name of Secular School Attending:

Parent/Guardian Volunteers are always needed for school programs. I/We are available on:

Sundays _____ Mondays _____ Wednesdays _____ (please check all that apply).

IN CASE OF INJURY OR ILLNESS OF A CHILD AT SCHOOL EVERY EFFORT WILL BE MADE TO CONTACT THE PARENT/GUARDIAN. **THE FOLLOWING WILL REMAIN IN EFFECT UNLESS REVOKED BY PARENT/GUARDIAN:**

IF INJURY OR ILLNESS IS MINOR, GIVE FIRST AID? ___ YES ___ NO

IF INJURY IS SERIOUS AND PARENT/GUARDIAN CANNOT BE CONTACTED, DO YOU WISH YOUR PERSONAL PHYSICIAN OR DENTIST CONTACTED? ___ YES ___ NO

NAME OF PHYSICIAN _____

ADDRESS OF PHYSICIAN _____

PHONE # OF PHYSICIAN _____

NAME OF DENTIST _____ PHONE # OF DENTIST _____

ADDRESS OF DENTIST _____

--Please turn over for more important information needed--

IF A PARENT/GUARDIAN CANNOT BE REACHED IN CASE OF EMERGENCY, GIVE THE NAME(S) OF PERSON(S) TO BE NOTIFIED:

EMERGENCY CONTACT #1 _____
ADDRESS _____
PHONE # _____

EMERGENCY CONTACT #2 _____
ADDRESS _____
PHONE # _____

LIST **ALL ALLERGIES AND/OR MEDICATIONS*** (USE ADDITIONAL SHEETS OF PAPER AND ATTACH TO THIS FORM FOR MORE INFORMATION):

**Any medications (i.e. Benadryl, Epipen) that may need to be administered during school time require a separate medical form to be filed with this form. The medical form may be obtained in the office.*

LIST **ANY SPECIAL LEARNING NEEDS AND/OR DISABILITIES** (USE ADDITIONAL SHEETS OF PAPER AND ATTACH TO THIS FORM FOR MORE INFORMATION):

LIST **ANY PERSONAL INTERESTS, HOBBIES OR TALENTS** (USE ADDITIONAL SHEETS OF PAPER AND ATTACH TO THIS FORM FOR MORE INFORMATION):

____ PLEASE CHECK BOX IF YOU DO **NOT** WISH TO HAVE YOUR CHILD'S ADDRESS AND PHONE NUMBER LISTED ON THE CLASS DISTRIBUTION LIST.

____ PLEASE CHECK BOX IF YOU DO **NOT** WISH TO HAVE YOUR CHILD'S PICTURE AND NAME USED IN PUBLICITY INFORMATION IN SYNAGOGUE DOCUMENTS AND/OR PUBLICATIONS.

____ PLEASE CHECK BOX IF YOU DO **NOT** WISH TO HAVE YOUR CHILD'S PICTURE AND NAME USED IN PUBLICITY INFORMATION IN LOCAL AND NON-LOCAL PUBLICATIONS.

IN THE EVENT OF A MEDICAL EMERGENCY, I AUTHORIZE THE STAFF TO OBTAIN EMERGENCY MEDICAL TREATMENT FOR MY CHILD. I UNDERSTAND THAT I WILL BE CONTACTED IMMEDIATELY.

PARENT/GUARDIAN'S NAME

PARENT/GUARDIAN'S SIGNATURE

Please note: Incomplete information and/or failure of payment regarding registration will cause a delay in processing and may preclude your child from attending Religious School.

The safety and partnership between the school and our families is our #1 priority.

Thank You!