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 2019-2020/5780

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, 2019*** *must be accompanied by a* ***$25.00 registration fee****. Registration forms received* ***after May 31, 2019*** *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!