

JCC-CHABAD HEBREW SCHOOL
OF
LONG ISLAND CITY

REGISTRATION FORM

STUDENT INFORMATION

Student's Name: _____

Student's Hebrew Name: _____

Birth Date: ____/____/____

Grade Entering: _____

School Name & City: _____/_____

Names and ages of other children in family:

ABOUT YOUR CHILD

Does your child read basic Hebrew? Yes ____ No ____

Previous Religious School Education: _____

Does your child have any learning difficulties with general studies?

If Yes, Please explain: _____

Is there anything you would like us to know about your child that would help us to better attend to him/her: _____

PARENT INFORMATION

Father's name: _____ Jewish: Yes ___ No ___

Home # _____ Mobile # _____

E-mail _____

Occupation _____ Work # _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mother's name: _____ Jewish: Yes ___ No ___

Home # _____ Mobile # _____

E-mail _____

Occupation _____ Work # _____

Address: _____

City: _____ State: _____ Zip Code: _____

GENERAL INFORMATION

Would you be willing to help with school activities? Yes ___ No ___

Does either parent have any special resources or skills to offer our children or teachers? If yes please provide explain:

◆ We grant permission for our child to be photographed in an individual or group picture which may be used by the school for P.R.

PRINT NAME: _____ SIGN: _____

◆ The following are authorized to take my child to and from school:

Name: _____ Phone _____

Name: _____ Phone _____

MEDICAL INFORMATION

Any special medical circumstances or allergies: _____

Medication child is taking on a regular basis: _____

Allergic reactions to medication: _____

MEDICAL EMERGENCIES

In case of emergency, when neither parent can be reached, provide names of two people who will take responsibility for your child.

Name: _____ Relation to child: _____

Home / Work #: _____ Mobile # _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Relation to child: _____

Home / Work #: _____ Mobile # _____

Address: _____

City: _____ State: _____ Zip Code: _____

If parents cannot be reached and emergency medical advice is needed, permission is given to the Hebrew School staff to phone my child's doctor:

Doctor: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Doctor's hospital affiliation: _____

In case of medical emergency requiring immediate emergency care, I authorize the paramedics to take my child to the nearest hospital:

Father's Signature _____ Date ____/____/____

Mother's Signature _____ Date ____/____/____