Chabad Hebrew School Registration

ב"ה

Use Separate Form for Each Child

Name of child: ____ Age: __________

Birthdate ___/___/___ Hebrew Name: ____

Home Address: ____

Other Parent Address (if different) ____

Telephone: ( ) ___________________ Work ( ) _______________ Cell ( ) ________________

E-mail:____

Previous Hebrew School: ____

Name of Day School: ____ Grade: _____________

Mother's Hebrew/English Name: ____

Father's Hebrew/English Name: ____

Is the Natural mother of the child Jewish? ____

Has there been a conversion or adoption in the family? If yes, please specify: _____________________

Child's Medical information

Doctor: ____ Phone Number: _____________

Address: ____

Allergies or other Medical Condition: ____

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Emergency contact: ________________________________ Phone Numbers: __________________

I (We) hereby enroll our child in the Chabad Hebrew School of West Bay.

In the event of a medical emergency and neither parent can be reached, medical treatment may be provided as necessary.

I (We) hereby permit my child to participate in all school activities, join in class and school trips on and beyond school properties.

My (our) child may be photographed and the pictures may be used for publication by Chabad.

__________________________________ ____________________

Signature of Parent or Guardian **Date**

Please mail form to the following address along with your payment for tuition as soon as possible:

Chabad of West Bay
3871 Post Road, Warwick RI 02886
(401)884-7888