



2019 -2020 REGISTRATION FORM GRADES PRE-KGN – 5TH

ALL OF THE INFORMATION BELOW MUST BE FILLED OUT COMPLETELY

Family (Last) Name: _____ Home Phone: _____

Student's First Name: _____ Student's Last Name: _____

Date of Birth (MM/DD/YY): _____ Male Female

New Student Returning Student B'nai Torah Employee **check all that apply**

Street Address: _____ Mom Cell #: _____

City & Zip Code: _____ Dad Cell #: _____

Parent's Name (s): _____ Occupation: _____ Work#: _____
 _____ Occupation: _____ Work#: _____

Mom's E-mail: _____ Dad's E-mail: _____

Marital Status: Married Divorced Separated Widowed
 With whom does your child live? _____

Student's Hebrew Name: _____ Name of Secular School: _____

We use text messaging as a means of communication to our Mirochnick Religious School families. I do _____ / do not _____ give permission for text messaging. If the above is not checked permission will be implied.

Tuition for Grades K thru 5: Tuition Includes Membership to Youth Group (Chalutzim/Bonim)

Grade in 9/1/2019	Regular Tuition	Tuition Discount if paid in full by August 30	Sibling Discount 1 per family
PRE-KGN	\$525	\$36	\$36
K & 1	\$750	\$36	\$36
2 thru 5	\$980	\$36	\$36

The Mirochnick Religious School at B'nai Torah Congregation may photograph or video tape my child(ren) during school hours and post pictures (with/without names) in synagogue and local newsletter communications, either print or on the internet.

I do _____ / do not _____ give permission for my child.

If the above is not checked permission will be implied.

(Please turn over)

MEDICAL INFORMATION AND RELEASE FORM

Understanding your child's medical, physical, or psychological needs will help our staff secure your child's safety, well-being, and productivity in the classroom. Please indicate the applicable conditions below, and elaborate as needed:

Student's Name: _____ Grade: _____

Please list current medication with dosage your child is taking:

Medical Concern	Medication Dosage	Medical Concern	Medication Dosage
<input type="checkbox"/> IEP		<input type="checkbox"/> ADD/ADHD	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Learning Disabled	
<input type="checkbox"/> Perceptual Problems		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Hearing Loss	
<input type="checkbox"/> Visual Problems		<input type="checkbox"/> Speech Problems	
<input type="checkbox"/> Emotional Disturbances		<input type="checkbox"/> Allergies	
<input type="checkbox"/> Other (Please Specify):		<input type="checkbox"/> Other (Please Specify):	

Is there any other information you would like to share with us to help us provide your child with the most rewarding educational experience. (Please Print)

*****In the event of an emergency, surgical or otherwise, if I cannot be reached I hereby give permission for my child to be transported to the nearest medical facility and specifically authorize the representative of B'nai Torah Congregation to select a physician and/or authorize medical treatment, including hospitalization, anesthesia, injection, surgery, or other measures which he/she feels are in the best interest of my child.**

Signature: _____ Date (MM/DD/YY): _____

Name (Please Print): _____

EMERGENCY CONTACT INFORMATION (other than parents):

NAME (Please Print): _____ **PHONE #:** _____

RELATIONSHIP (Please Print): _____

NAME OF CHILD'S PHYSICIAN (emergency only): _____

TELEPHONE NUMBER OF CHILD'S PHYSICIAN (emergency only): _____

INSURANCE CARRIER NAME (Please Print): _____

INSURANCE POLICY #: _____