B”H

HEBREW SCHOOL REGISTRATION FORM 2016-17

Complete the registration form below, drop off or mail it to:
17315 Sunset Blvd. Pacific Palisades, CA 90272
For more information, call 310-454-7783
www.ChabadPalisades.org

STUDENT INFORMATION

1. Student Name	DOB	Age	Gender	Grade Entered Sept. 2016
Address	City/State/Zip			
School				Student’s Hebrew Name
2. Student Name	DOB	Age	Gender	Grade Entered Sept. 2016
School				Student’s Hebrew Name

PARENT INFORMATION

Mother’s Name	Home Phone ( )
Address (If different than child)	Work Phone ( )
Email Address	Cell Phone ( )
Father’s Name	Home Phone ( )
Address (If different than child)	Work Phone ( )
Email Address	Cell Phone ( )

EMERGENCY CONTACT INFORMATION

Additional Emergency Contact Name		Home Phone ( )	
Home Address		Work Phone ( )	Cell Phone ( )
List all persons authorized to pick-up camper from campus			
Name	Relationship	Home Phone ( )	Cell Phone ( )
Name	Relationship	Home Phone ( )	Cell Phone ( )
Name	Relationship	Home Phone ( )	Cell Phone ( )

PRICING & SCHEDULE

There is a 10% discount for each additional child.
Tuition and fees must accompany the registration form. Please make checks payable to: Chabad of Pacific Palisades.
No one will be turned away for lack of funds, payment plans are available.

☐ Sunday or Thursday Options	Sunday 10am-12pm Thursday 4-6pm	$1000
☐ Tutoring	1 hr. Session Upon Request	$65/Home Session $50/Chabad Session

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HEALTH FORM

Please use one Health Form per student only.
You may photocopy this form for additional forms.

Student Name _____
Please check below if your child currently has or has suffered from the following:
☐ Serious Illness/Operation ☐ Ear Trouble ☐ Kidney Disease ☐ Glasses/Contact Lens ☐ Asthma ☐ Eye Trouble

☐ Rheumatic Fever ☐ Hearing Aid ☐ Seizures ☐ Heart Disease ☐ Tuberculosis ☐ ADD/ADHD

Please explain any items checked (attach an additional page if necessary) _____
_____

Are your child’s immunizations current for the State of California school requirements? ☐ Yes ☐ No

Does your child have any food, medication, insect bite or sting allergies that we should be aware of? ☐ Yes ☐ No

If yes, please explain. _____
_____

Does your child have any behavior, emotional, physical or mental health problems that we should be aware of ? ☐ Yes ☐ No

If yes, please explain. _____
_____

Has your child had a tetanus shot? ☐ Yes ☐ No Date of last tetanus shot? _____

Name of your child’s physician _____ Phone _____

Address _____ City _____

Name of Insurance _____ Group or Medical # _____

Name of your child’s dentist/orthodontist _____ Phone _____

Address _____ City _____ Zip _____

All prescription medications must have an accompanying written statement from the physician detailing the purpose and method of dispensing the medication (see below.) Prescription medications must be in the original, labeled container.

Nature of condition (s) requiring medication _____
_____

Name of Prescribed Medication	Dosage	Time of Administration	Adverse Reactions?
_____	_____	_____	_____

PARENTAL RELEASE AND CONSENT

All of the forms must be on file in the School office prior to the first day of School. Parents are responsible for keeping the center informed of any changes in the emergency information.
If your child becomes ill during the day, you or your emergency contact will be called to take your child home. We will not release your child to anyone other than the parents unless we have authorization in writing in the school office. If someone else will be picking up your child, please fill out the permission slip provided by the teachers/counselors.
In case of an accident or any emergency requiring immediate attention, our first attempt will be to reach the parent, then follow the instructions on the emergency form. We will call the doctor and/or paramedics. Our staff will take every precaution necessary to provide and implement a SAFE environment for your children.
In case of a disaster (i.e.: earthquake, fire etc.) that renders our facility unsafe, we would evacuate to the inner gate on the corner of Los Liones and Sunset Blvd. Also our staff will be assisting you with more detailed information upon your arrival so that you can pick your child up safely.

I certify that no information concerning the health of this student has been withheld or misrepresented. I authorize our physician to provide further medical history should it be deemed necessary.

This completed form may be photocopied for trips off campus. I hereby give permission, for my child registered in Chabad Hebrew School, to be taken by school bus on all outings and trips. I give permission to Chabad Hebrew School to use School photos of my children in any publicity.

_____ _____
Signature of Parent or Guardian Date