



Congregation Beth Shalom

354 maitland avenue | teaneck, nj 07666-3026
(201) 833-2620 | (201) 833-2323 [fax]
www.cbsteaneck.org

<i>Office Use Only:</i>	
Deposit:	_____
Late Fee (if any):	_____
Add'l Paid:	_____
Amount Due:	_____

Religious School Registration Form

**** Please PRINT all information ****

Student's Name: _____ Date of Birth: _____
Last First Hebrew

Previous religious education (if any): _____ Entering Grade _____ in Public School
Name of School

Father's Name _____ Mother's Name _____
Last First Hebrew Last First Hebrew

Mailing Address: _____

Congregation Affiliation: _____ Phone #: _____

E-mail address(es): _____

Cell Phone # (Father): _____ (Mother): _____

If parents are divorced or separated, should mailings regarding child(ren) go to an additional address: Yes _____ No _____

If so, please provide additional address: _____

IMPORTANT: PARENT INVOLVEMENT

Jewish education is a family affair. We need you to spend some time with us in order to enrich the quality of education for your child(ren). Many of these tasks involve as little as a few hours per year.

___ Class Parent ___ Assist at school events ___ School Office ___ Photography of school events ___ Publicity ___ Other

Another way that you can help is by sharing a hobby, talent or experience. Examples: visited Israel ; traveled to or lived in a Jewish community outside the United States; skilled in needlework; Jewish cooking, music, crafts, drama, storytelling, multi-media, Jewish current events, history, etc.

I can share my knowledge of _____

Signature _____ Date _____

TRAVEL CONSENT

I give consent for my child, _____, to be driven to and from field trips by parent volunteers or bus.

Signature _____ Date _____



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Religious School Emergency Medical Information

**** Please PRINT all information ****

Student's Name: _____ Date of Birth: _____
Last First

In case of injury or illness of a child at school, every effort will be made to contact the parent or guardian. The following instructions WILL REMAIN IN FORCE unless revoked by the parent or guardian. **If injury is serious and parent/guardian cannot be contacted, should we contact your personal physician or dentist?** Yes _____ No _____

NAME OF PHYSICIAN: _____ Phone #: _____

Mailing Address: _____

NAME OF DENTIST: _____ Phone #: _____

Mailing Address: _____

If you cannot be reached in case of emergency, please give the name(s) of people to be notified:

(1) Name: _____ Phone #: _____

Mailing Address: _____

(2) Name: _____ Phone #: _____

Mailing Address: _____

Does your child have any of the following problems?

___ Vision ___ Medication ___ Allergy ___ Hearing ___ Educational

In the event of a medical emergency, I authorize the staff to obtain emergency medical treatment for my child(ren). I understand that I will be contacted immediately, was will my physician.

Parent's Name (print) Parent's Signature Date

PHOTOGRAPHY CONSENT

I hereby grant full permission to Congregation Beth Sholom and its direct affiliates to use either my child's photograph and name (if necessary) in any publication or advertising materials (printed or electronic). This consent also serves to waive all rights of privacy or compensation which I may have in connection with the use of my child's photograph and/or name. I also acknowledge that Congregation Beth Sholom has the right to crop or treat such photographs at its discretion.

Signature _____ Date _____