



**TEMPLE
BETH
RISHON**

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SUNDAY/HEBREW/HIGH SCHOOL
REGISTRATION FORM
2009-2010

PLEASE PRINT CLEARLY OR TYPE

YOUR CHILD

Family Name _____ **Child's Name** _____
Hebrew Name _____
Address _____ **Town** _____ **Zip** _____
Phone Number _____ **E-mail Address** _____
Parent or Guardian _____
Birth Date ___/___/___ **Grade** _____ **Public School** _____

QUESTION ON LEARNING FACILITY

Does your child have any learning difficulty/disability, which the school should be aware of in order to make the learning process easier?

INFORMATION ON SIBLINGS

Name _____ **Birth Date** ___/___/___ **Grade** _____
Name _____ **Birth Date** ___/___/___ **Grade** _____
Name _____ **Birth Date** ___/___/___ **Grade** _____

PARENTS

Father's Name _____ **Mother's Name** _____
Business Phone _____ **Business Phone** _____
Cell Phone _____ **Cell Phone** _____
E-mail Address _____ **E-mail Address** _____
Marital Status _____

Preferred schedule 2009/ 2010

Alef/Bet: Su/ Tu_____ or Tu/ Th_____

Gimel/Dalet: Su/ Th_____ or Tu/ Th_____

MEDICAL INFORMATION

Existing Medical Problems _____

Medicine(s) Your Child Takes _____

Date of Last Tetanus Shot ____ / ____ / ____

Allergies _____

EMERGENCY INFORMATION

If parents cannot be reached for an emergency, please call:

Name #1 _____ Relationship _____ Phone _____

Name #2 _____ Relationship _____ Phone _____

Doctor's Name _____ Phone _____

Hospital Preference _____

INSURANCE

Insurance Carrier _____ Policy # _____

Other _____ Policy # _____

NOTE ON AUTHORIZATION FORM

The authorization granted by this form will be used only after efforts have been made to contact the parent(s) listed above.

**AUTHORIZATION AND RELEASE FOR PEDIATRIC EMERGENCY
MEDICAL AND/OR SURGICAL TREATMENT**

In the event that my child, _____, requires medical care and/or treatment, I hereby authorize Beth Rishon and the doctors and/or hospital selected by it to take and to perform all procedures which are deemed necessary, and render any indicated treatment, including the administration of anesthesia, if needed, and the performance of an operation, if in the opinion of said doctor(s) the same necessary.

I hereby release Beth Rishon from any liability arising out of its use of the reliance on this authorization.

Signed _____ Date _____ Relationship _____

Child's Name _____

Address _____ Town _____ Zip _____