



**TEMPLE
BETH
RISHON**

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TEMPLE BETH RISHON
SUNDAY/HEBREW/HIGH SCHOOL

REGISTRATION FORM

585 Russell Avenue
Wyckoff, NJ 07481
Phone: 201-891-4466 Fax: 201-891-0508
E-mail: **Templeoffice@bethrishon.org**

2011-2012

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 _____

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** _____