



SHEVES ACHIM HEBREW SCHOOL REGISTRATION FORM 2015-2016

Child's Name: _____

Physician: _____

Physician phone: _____

*Two emergency contacts: _____

*Relevant medical information (please include food allergies):

*Would you like to be informed about our developing additional program for elementary school students? Y N

*I grant permission for my child to attend Sheves Achim Hebrew School and take part in all the activities and trips.

*I grant permission to Sheves Achim Hebrew School to photograph or video my child and use those pictures for printed or online materials.

*In case of a medical emergency, I understand that every effort will be made to contact the parents or guardian. I give permission to the Hebrew School staff to phone my child's physician for medical advice. In the event I cannot be reached, I give permission to the physician selected by Sheves Achim Hebrew School to administer proper care for my child. I will not hold Sheves Achim Hebrew School liable if my child suffers any injury during school time.

*I agree to pay all tuition fees unless a different agreement has been arranged with Rabbi Diskind.

*Parent Signature _____