Hebrew School Registration Form 2008 – 2009

Date: ___________

New Student
Returning Student

Student Information:

English Name : _______________Hebrew Name: _______________
Student's Birthdate: _______/_______/______ ❒ Male ❒ Female
Address:___________________ City:_________________ Zip Code:__________ Home Phone No. __________
Student's Grade in September 2008 _______ Primary School ______________________________
Are there any important educational or medical needs that we should know about your child?
____
Does your child have a friend that he/she would like to have in his/her class?

Child #2

English Name : _______________Hebrew Name: _______________
Student's Birthdate: _______/_______/______ ❒ Male ❒ Female
Address:___________________ City:_________________ Zip Code:__________ Home Phone No. __________
Student's Grade in September 2008 _______ Primary School ______________________________
Are there any important educational or medical needs that we should know about your child?
____
Does your child have a friend that he/she would like to have in his/her class?

Child #3

English Name : _______________Hebrew Name: _______________
Student's Birthdate: _______/_______/______ ❒ Male ❒ Female
Address:___________________ City:_________________ Zip Code:__________ Home Phone No. __________
Student's Grade in September 2008 _______ Primary School ______________________________
Are there any important educational or medical needs that we should know about your child?
____
Does your child have a friend that he/she would like to have in his/her class?

How did you hear about our school? ____

Parent Information:

Father's Full Name: (Mr./Dr.)______________________ Hebrew Name ___________________

Mother's Full Name:(Mrs./Ms./Dr.)___________________ Hebrew Name ___________________

_____ Single Parent (Mother/ Father) _____ Parents Divorced _____ Parents Separated

_____ Mother Jewish ______Father Jewish

Has anyone in your family been adopted or converted? ____

Father's Work Phone:____________________Occupation: _________________Company Name: ___________

Mother's Work Phone:____________________Occupation: _________________Company Name: ___________

E-mail Address: Mother_______________________ Father______________________

Cell phone numbers: Mother ____________________ Father _____________________ *** PLEASE FILL OUT**

Grandparents Information:

Name: _________________________________

Address:_______________________________

City, State, Zip Code ______________________

Phone Number: ___________________________

E-Mail__________________________________

Can we put them on our mailing/e-mail list? Y/N

Name: _____________________________________

Address: ___________________________________

City, State, Zip Code __________________________

Phone Number: ______________________________

E-Mail _____________________________________

Can we put them on our mailing/e-mail list? Y/N

Sibling Information:

Child's Name: __________________ Age:______

Child's Name: __________________ Age:______

Emergency Contact Information:

Child's name __________________

In the event of an emergency if we are unavailable, we authorize the following individuals to care for our child:

Name: _____________ Phone number: ________________

Physician's Name ______________ Phone No. ______________

Dentist's Name ______________ Phone No. ______________

Please indicate any known allergies: _______________________

If we, our emergency contact, or our physician, cannot be reached in the event of a medical emergency, we hereby give permission to the physician or hospital selected by the school to hospitalize and/or secure proper treatment for our child named above. We understand that any costs incurred will be our responsibility.

Date: __________ Signature: _________________________

Please mail the completed form in the enclosed envelope to:

CTC of Bucks County
c/o Suri Max
9 Surrey Drive
Churchville, PA 18966

Payment options:

- ❒ **Check** (Please make checks payable to CTC)
- ❒ **Credit Card**
- ❒ **Full Payment ($700)**
- ❒ **Early Bird Special ($650)**
- ❒ **I am interested in a payment plan.**

❒ Visa ❒Mastercard ❒Discover

Credit Card #

____

Name as it appears on your card

____

Expiration Date ______/______

I authorize CTC/Total to charge my credit card:

- ❒ $700
- ❒ $100 per month
- ❒ Other amount

Signature______________________