

School Registration



Name (Last, First)	Grade	Circle (one or both)	
_____	_____	Religious	Hebrew
_____	_____	Religious	Hebrew
_____	_____	Religious	Hebrew
_____	_____	Religious	Hebrew

Member Fees:			Fee	Total
Kita Gan (Preschool)	_____	X	\$250 =	_____
Kita Alef (Grades 1 & 2)	_____	X	\$550 =	_____
Additional Child	_____	X	\$525 =	_____
Kita Bet (Grades 3 & 4)	_____	X	\$750 =	_____
Additional Child	_____	X	\$700 =	_____
Kita Gimmel (Grades 5, 6, 7, & 8)	_____	X	\$750 =	_____
Additional Child	_____	X	\$700 =	_____
Confirmation (Post Bar/Bat Mitzvah)	_____	X	\$250 =	_____
Siddur Fee Friday Service (Kita Bet and Gimmel)	_____	X	\$50 =	_____
Siddur Fee Saturday Service (Kita Bet and Gimmel)	_____	X	\$50 =	_____

TOTAL EDUCATION FEE: _____

DEPOSIT: (25% required before start of class) _____

BALANCE of Tuition Due (total Tuition – Deposit) _____

EDUCATION COMMITTEE USE ONLY

Received: _____ Check # _____ By Ed Comm. Member

Registration Continued



Student Name (Please Print)

Today's Date_____

Last

First

Hebrew

Date of Birth

Student Address:

Number

Street

City

Zip

Parent or Guardian Name(s)

Last

First

Relationship

Phone

Last

First

Relationship

Phone

In Case of Emergency: (other than parent listed above)

Last

First

Relationship

Phone

Last

First

Relationship

Phone

Student lives with () Mother () Father () Both () Other

Father's Employer _____ Work Phone _____

Mother's Employer _____ Work Phone _____

Has student previously attended religious school? _____

Secular Grade for this upcoming Fall _____

CONGREGATION BETH SHALOM

AUTHORIZATION TO OBTAIN MEDICAL CARE

I/we, am/are the undersigned parents(s) or legal guardian(s) of _____, who was born on _____.

I hereby authorize the staff of Congregation Beth Shalom Religious School, into whose case _____ has been entrusted, to consent to medical, dental, surgical or hospital care, treatments or diagnosis for _____, under Section 6910 of the California Family Code.

I further authorize the staff of Congregation Beth Shalom Religious School to receive physical custody of _____ under section 1283 (a) of the California Health and Safety Code upon completion of any treatment, and I specifically instruct any treating health facility to surrender the physical custody of _____ to any member of the staff of Congregation Beth Shalom Religious School.

Parent or Legal Guardian - Signature

Date

Name of Student's Physician: _____

Address and Phone of Physician: _____

Name of Student's Dentist: _____

Address and Phone of Dentist: _____

Allergies: _____

Medications Taken: _____

Insurance Information:

Name of Policy Holder: _____

Insurance Carrier: _____

Policy No. _____

Phone: _____

Does your child have any special needs? If so, Please describe below or enter "NONE".

