Temple Sinai Hebrew School

75 Highland Avenue
Middletown NY 10940
845-343-1861

Lucy Fox, Principal Joel M. Schwab, Rabbi

STUDENT REGISTRATION FORM

1. Student Information:

Child's Name:_____
Last First MI

Address:_____
Street City

_____
State Zip

Public School:_____Grade_____

Birthdate:_____Hebrew Name:_____

2. Parent/Guardian Information:

Name: Mother_____Cell#_____
Last First

Father_____Cell#_____
Last First

Home Phone:_____

Please notify Temple Sinai Hebrew School of any changes to the above information.

Temple Sinai Hebrew School
Student Health Form

Child's Name:_____Age_____

IN CASE OF INJURY OR ILLNESS EVERY EFFORT WILL BE MADE TO CONTACT THE PARENT OR GUARDIAN. THE FOLLOWING INSTRUCTIONS WILL REMAIN IN FORCE UNLESS REVOKED BY PARENT OR GUARDIAN.

(please circle)

If injury or Illness is minor give child first aid? **YES or NO**

Call Ambulance if needed? **YES or NO**

Name of Physician_____ Phone #_____

Name of Dentist_____ Phone #_____

IF YOU CANNOT BE REACHED IN CASE OF EMERGENCY, GIVE THE NAME OF PERSON TO BE NOTIFIED:

Name_____Relationship_____Phone#_____
Name_____Relationship_____Phone#_____

Please list any medical conditions, allergies, etc. that the school should be aware of:

_____

_____

IN THE EVENT OF A MEDICAL EMERGENCY, I AUTHORIZE THE STAFF OF TEMPLE SINAI TO OBTAIN EMERGENCY MEDICAL TREATMENT FOR MY CHILD. I UNDERSTAND THAT I WILL BE CONTACTED IMMEDIATELY.

Date:_____Parent Signature_____

If any medication are to be left in the Hebrew School office, please supply a doctors note with instructions.