

**JUMPIN' 4 JUDAISM**  
**THE BETH RADOM HEBREW & JEWISH LIVING PROGRAM**  
**STUDENT REGISTRATION FORM ACADEMIC YEAR 5772-73/2012-2013**

**STUDENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Province \_\_\_\_\_ Postal Code: \_\_\_\_\_

Student's Personal E-mail (if any) \_\_\_\_\_

Permission to use Email for: Office Only \_\_\_\_\_ Share w/Teachers \_\_\_\_\_

Hebrew Name \_\_\_\_\_

Secular School Grade as of September 2012: \_\_\_\_\_ Name of Secular School: \_\_\_\_\_

J4J Sunday location preferred: North/South

**PARENT/GUARDIAN INFORMATION:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ E-Mail \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ E-Mail \_\_\_\_\_

Home Address (if different from above): \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Province \_\_\_\_\_ Postal Code: \_\_\_\_\_

(Parent 1) Home Phone (\_\_\_\_) \_\_\_\_\_ Bus. Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ E-mail address: \_\_\_\_\_

(Parent 2) Home Phone (\_\_\_\_) \_\_\_\_\_ Bus. Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Student lives with: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**EDUCATIONAL INFORMATION**

At Congregation Beth Radom, we strive to establish an environment in which all types of learners may thrive. Information you provide about your child's learning strengths and challenges will assist in our efforts to accommodate and provide for those needs. Please also provide any IPRC information if available. My child has the following learning and/or behavior issue (please explain):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

**EMERGENCY MEDICAL INFORMATION**

Doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Card#: \_\_\_\_\_ Version Code: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_  
Group ID: \_\_\_\_\_ Plan: \_\_\_\_\_

Does your child have any illnesses or chronic conditions of which school personnel need to be aware (i.e., asthma, dietary restrictions, allergies, hearing, vision, speech)? If yes, please list and explain:

\_\_\_\_\_  
\_\_\_\_\_

Is your child taking any medications? If yes, please list:

\_\_\_\_\_  
\_\_\_\_\_

In case of a medical emergency, I authorize the staff at Congregation Beth Radom to obtain emergency medical treatment for my child.

I / We \_\_\_\_\_ understand and agree that in case of emergency or injury to \_\_\_\_\_ (Child's name), such action will be taken and medical treatment administered as deemed necessary by the school or its employees. I hereby release the school, its employees and agents from any claim or liability with respect to the same. I give the school such authorization that permits any person or hospital to provide such treatment to my child as may be advisable in the circumstances, and this shall be sufficient authority for so doing.

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notice to Parents/Guardians and Children- Collection and Release of Information: Information is collected pursuant to the Education Act. Limited information may be disclosed beyond the scope of Beth Radom. This may include the release of students' names, ages and grades, photographs, artwork, writing or other school related work to the media for publicity, displays, newsletters etc. If you do not consent to the release of information, please inform the Director of Education in writing prior to the commencement of the school year.

All information will be held in confidence, shared only as reasonably necessary to provide a positive quality educational experience for your child.