



# Temple Israel

A PROGRESSIVE CONSERVATIVE SYNAGOGUE

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Winter Springs, FL 32708-3002  
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## 2011-12 Religious School Registration

One Registration and one Schedule & Tuition form must be filled out/corrected for each child – Please Print.

DATE \_\_\_\_\_

MEMBER       NON-MEMBER

### Student

Last Name		First Name	Middle Name	
Child's <b>Hebrew</b> Name (in English)		Bat / Ben	Please Circle	
Father's <b>Hebrew</b> Name (in English)		Mother's <b>Hebrew</b> Name (in English)		
Address		City	Zip	
Birth date (mm-dd-yyyy)	Age	Grade Level in September		

### Father

Last Name	First Name	Home Phone		
(Home Address) Street	City	State	Zip	
(Business Address) Street	City	State	Zip	
Business Phone	Cell Phone/Pager	E-mail Address		

### Mother

Last Name	First Name	Home Phone		
(Home Address) Street	City	State	Zip	
(Business Address) Street	City	State	Zip	
Business Phone	Cell Phone/Pager	E-mail Address		

### Public School

Name	Address	Phone
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### Permissions

We often have activities that warrant photographing; these pictures are sometimes used for publicity in our bulletin, the local newspapers and other media. We also distribute classroom contact information so that our families may stay in touch with each other out side of class. If you have any questions please contact the office.

### Skills

Please let us know of any ways in which we can optimize your child's learning in class. How does your child best learn? What motivates your child? What work-arounds might we use in more difficult subjects, or situations?

I certify that all information is accurate.

Signature of Parent/Guardian

Date





**Temple Israel Religious School**  
**Emergency Medical Information 2011-12 (2 per student)**

**Student  
Photo**

Student's Last Name | First Name | Middle

Birth date (mm-dd-yy) | Age | Grade in Public School in September

Physician's Name | Phone

Physician's Address | City | Zip

Dentist's Name | Phone

Dentist's Address | City | Zip

If injury or illness is minor, do you authorize Temple Israel to administer first aid?  Yes  No

If injury or illness is serious & you can't be reached, do you wish your personal physician or dentist to be contacted?  Yes  No

Please explain any allergies or medical conditions of which the school needs to be aware:

Insurance carrier:

Policy number:

**Please turn form over**

**Please turn form over**



**Temple Israel Religious School**  
**Emergency Medical Information 2011-12 (2 per student)**

**Student  
Photo**

Student's Last Name | First Name | Middle

Birth date (mm-dd-yy) | Age | Grade in Public School in September

Physician's Name | Phone

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Please explain any allergies or medical conditions of which the school needs to be aware:

Insurance carrier:

Policy number:

**Please turn form over**

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**If you cannot be reached in case of an emergency, give the name(s) of the person(s) to be notified and/or to whom the child can be released:**

1.	<i>Name</i>	<i>Relationship</i>	<i>Phone</i>
	<i>Address</i>	<i>City</i>	<i>Zip</i>
2.	<i>Name</i>	<i>Relationship</i>	<i>Phone</i>
	<i>Address</i>	<i>City</i>	<i>Zip</i>
3.	<i>Name</i>	<i>Relationship</i>	<i>Phone</i>
	<i>Address</i>	<i>City</i>	<i>Zip</i>

I hereby grant permission to Temple Israel to call a physician/dentist for necessary medical care or hospitalization for my child in case of an emergency, after trying to notify me first. Further, I release Temple Israel; it's officers, agents and employees, from any and all liability.

Signature of Parent or Guardian	Date	
Phone #	Cell #	Pager #
Address		
City, Zip	E-mail Address	

**If you cannot be reached in case of an emergency, give the name(s) of the person(s) to be notified and/or to whom the child can be released:**

1.	<i>Name</i>	<i>Relationship</i>	<i>Phone</i>
	<i>Address</i>	<i>City</i>	<i>Zip</i>
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	<i>Address</i>	<i>City</i>	<i>Zip</i>
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