



Chabad Hebrew School 2018-2019 Registration Form

A project of
The Lori Schottenstein
Chabad Center

Family Name:

Mother's Name: _____
 Mother's Hebrew Name: _____
 Address: _____

 City: _____ Zip: _____
 Home Phone: _____
 Work Phone: _____
 Cell Phone: _____
 Email: _____

Father's Name: _____
 Father's Hebrew Name: _____
 Address: _____

 City: _____ Zip: _____
 Home Phone: _____
 Work Phone: _____
 Cell Phone: _____
 Email: _____

Emergency Contacts

Name: _____ Relationship: _____ Phone: _____
 Name: _____ Relationship: _____ Phone: _____
 Children's Pediatrician: _____ Phone: _____
 Address: _____ City: _____
 Insurance Company: _____ Policy #: _____

Contact for Emergency Medical Treatment

I give permission for emergency medical treatment, to be used only if I cannot be reached immediately.

Parent Signature: _____ Date: _____

Child 1

Enrolling in:

- Regular Hebrew School
- First Taste (ages 3-5)

Child's Name: _____ Hebrew Name: _____
 Date of Birth: _____ Time: _____ AM /PM Jewish Birthday: _____
 School: _____ Grade: _____
For new Students Enrolling: Hebrew Reading: None Somewhat Well
 Previous Jewish Education: Yes No If yes, where? _____
 Does the child have any special dietary needs, health situations, or any specific learning challenges?
 (Specify): _____

Child 2

Enrolling in:

- Regular Hebrew School
- First Taste (ages 3-5)

Child's Name: _____ Hebrew Name: _____
 Date of Birth: _____ Time: _____ AM /PM Jewish Birthday: _____
 School: _____ Grade: _____
For new Students Enrolling: Hebrew Reading: None Somewhat Well
 Previous Jewish Education: Yes No If yes, where? _____
 Does the child have any special dietary needs, health situations, or any specific learning challenges?
 (Specify): _____

Child 3

Enrolling in:

- Regular Hebrew School
- First Taste (ages 3-5)

Child's Name: _____ Hebrew Name: _____
 Date of Birth: _____ Time: _____ AM /PM Jewish Birthday: _____
 School: _____ Grade: _____
For new Students Enrolling: Hebrew Reading: None Somewhat Well
 Previous Jewish Education: Yes No If yes, where? _____
 Does the child have any special dietary needs, health situations, or any specific learning challenges?
 (Specify): _____

Please list other children that are not enrolled in Chabad Hebrew School

Child's Name: _____ Child's Name: _____
 Hebrew Name: _____ Hebrew Name: _____
 Date of Birth: _____ Date of Birth: _____

Tuition

Child 1

- First Taste (ages 3-5) \$350 _____
- Non Member Regular \$1,050 _____
- Member Regular* \$750 _____

- I have completed my membership form*
- I will be paying in installments:
 - monthly installments
 - quarterly installments

Child 2 (5% discount for siblings)

- First Taste (ages 3-5) \$330 _____
- Non Member Regular \$1,002 _____
- Member Regular* \$718 _____

Name: _____

Card Type: _____

Child 3 (5% discount for siblings)

- First Taste (ages 3-5) \$310 _____
- Non Member Regular \$1,002 _____
- Member Regular* \$718 _____

Card Number: _____

CVV2: _____ Exp. Month/Year: _____

TOTAL TUITION** _____

Online form also available at columbuschabad.com.

Please mail to: Chabad Hebrew School
 6220 East Dublin-Granville Rd.
 New Albany, OH 43054