



542 S. New Middletown Rd. Media, PA 19063
Bethisraelmedia.org | 610-566-4645 Ext. #5

Building Relationship

Living Jewishly

Finding Meaning

HEBREW SCHOOL REGISTRATION AND RELEASE FORM

School year 2019-2020 תשע"ט – תש"פ

Please complete both forms, with accurate and complete information

Student's Name _____ Hebrew Name _____

Address _____ Home phone _____

Date of Birth _____ Jewish Calendar Date of Birth _____

Secular School _____ School grade (entering 9/2019) _____

PARENT INFORMATION:

Parent 1 Name _____ Phone (work) _____

E-mail _____ Cell phone _____

Address and phone (if different from above) _____

Parent 2 Name _____ Phone (work) _____

E-mail _____ Cell phone _____

Address and phone (if different from above) _____

PICK-UP ARRANGEMENTS:

Who is authorized to pick up student?

Sunday _____

Tuesday _____

WAIVER:

I/We grant permission for my child to participate in all activities for the grade in which he/she is enrolled.

I/We release Congregation Beth Israel and its officers, employees, agents, and volunteers of any liability arising out of my/our child's participation in its Hebrew School program.

Parent Signature _____ Date _____

PHOTOGRAPHY WAIVER:

I/We give permission to Beth Israel to photograph my child _____ for use in all legal media regarding the Hebrew School for the calendar year of 2019-2020.

Parent Signature _____ Date _____



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STUDENT MEDICAL FORM

Student's Name _____ Grade _____

Address _____ Date of Birth _____

Parent 1 Name _____ Home # _____

Work # _____ Cell # _____

Parent 2 Name _____ Home # _____

Work # _____ Cell # _____

Health Insurance Company _____ Policy # _____

Name and Phone # of Student's Primary Physician _____

Allergies & Special Medical Information (food and other allergies, medication your child takes, etc):

Please describe any other health condition of which the staff should be aware: _____

In the events of an emergency, if parents cannot be reached, please notify:

Primary Contact _____ Phone _____ Cell _____

Relationship to student _____

Secondary Contact _____ Phone _____ Cell _____

Relationship to student _____

Parental consent, acknowledgement and waiver : I hereby give permission to the Beth Israel staff to seek emergency medical treatment for my child if they deem it necessary. I agree to the release of any record necessary for insurance purposes. I give permission to the Beth Israel staff to arrange necessary related transportation. In the event that I cannot be reached in an emergency, I hereby give permission to the physician/health care provider selected by the Beth Israel staff to secure and administer treatment, including hospitalization, for my child. I give permission to any health care provider, such as a hospital or physician, to share my child's medical information with the Beth Israel staff, for treatment purposes.

I hereby release Congregation Beth Israel and all of its employees, agents, officers, and volunteers from any liability whatsoever, including but not limited to, liability for personal injury arising out of or connected with my child's health or medical condition or any acts or omission by Beth Israel or its employees, agents, officers, and volunteers relating to my child's health or medical condition, including but not limited to, any acts or omissions relating to the administration of medical or other treatment.

Parent Signature _____ Date _____