

CHABAD HEBREW SCHOOL REGISTRATION 2018-19

5450 OCEANVIEW TERRACE. NANAIMO, BC V9V 1G7
WWW.JEWISHNANAIMO.COM 250-616-0109

CHILD 1

First Name:		Middle Name:	Last Name:
Hebrew Name:			Gender: Male/Female
Age:	Date of Birth:	To determine your child's Jewish birthday, what time of day was your child born?	
Grade:	School:		

CHILD 2

First Name:		Middle Name:	Last Name:
Hebrew Name:			Gender: Male/Female
Age:	Date of Birth:	To determine your child's Jewish birthday, what time of day was your child born?	
Grade:	School:		

CHILD 3

First Name:		Middle Name:	Last Name:
Hebrew Name:			Gender: Male/Female
Age:	Date of Birth:	To determine your child's Jewish birthday, what time of day was your child born?	
Grade:	School:		

FAMILY INFORMATION

Father's Name:		Hebrew Name:	
Cell Number:		Email:	
Mother's Name		Hebrew Name	
Cell Number:		Email:	
Address:		Home Phone:	
City:		Province:	Postal Code:

RELIGIOUS & EDUCATIONAL HISTORY

Are the child/children's parents Jewish? Mother Father

Were there any conversions or adoptions in the family? Yes No

If Yes, please explain:

Does your child have any learning difficulties with general studies? Yes No

If yes, please describe:

MEDICAL INFORMATION (CONFIDENTIAL)Up to date with vaccinations? Yes No

Describe any medical information we should be aware of such as allergies, or any special needs of your child.

Care Card Number: _____

In case of illness or injury of a child, every effort will be made to contact the parent or guardian.

In an emergency, call:

Name:

Home Phone:

Cell:

Relationship to child:

 I give my consent for a staff member to call a medical practitioner or ambulance for my child in the case of accident or illness, if I cannot immediately be reached. I give my consent for emergency medical treatment to be administered to my child in case of an injury.**PAYMENT**

Tuition Fee: \$340

 Single payment of \$340 \$340 over 9 payments processed on the first of every month (October- June) (credit card or post dated cheques only)**Payment Policy** There will be no refunds provided for days missed due to family holidays, activities, child's illness or emergency closure of Chabad Hebrew School.

No child will be turned away due to lack of funds

 Payment will be mailed to:
Chabad Hebrew School
5450 Oceanview Terrace
Nanaimo, BC V9V 1G7 Charge my credit card

Card Number

Exp: ___/___

CVV:

Comments:

 I AFFIRM THAT ALL THE INFORMATION PROVIDED IN THIS FORM IS TRUE.**Parent/Legal Guardian Signature****Date**

Looking forward for a great year at Chabad Hebrew School!

