

Beth Jacob HEBREW SCHOOL at Beth Tfiloh  
**ENROLLMENT APPLICATION FOR 2010-2011**

Congregation Membership \_\_\_\_\_

**Student Information**

Name of Student \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_  Male  Female

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

Name of Day School \_\_\_\_\_ Grade as of September 2010 \_\_\_\_\_

**Parent Information**

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email address \_\_\_\_\_ Email Address \_\_\_\_\_

**Family Information**

Number of Children in Family \_\_\_\_\_

Siblings at Beth Tfiloh Hebrew or Day School

	<u>Name</u>	<u>Grade</u>
1.	_____	_____
2.	_____	_____

*Please complete both sides of this form and return with a \$50.00 non-refundable deposit which will be applied to your tuition. Make checks payable to:*

Beth Tfiloh Community Hebrew School  
3300 Old Court Road  
Baltimore, MD 21208  
Phone: 410-486-1905

**PLEASE FILL IN ALL EMERGENCY INFORMATION ON THE REVERSE SIDE OF THIS APPLICATION WHICH WILL COMPLETE THE ENROLLMENT PROCESS.**

**EMERGENCY INFORMATION  
2010-2011**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

**PERSON AUTHORIZED TO PICK UP CHILD:**

Name and relationship to child \_\_\_\_\_

Daytime phone \_\_\_\_\_ Cell phone \_\_\_\_\_

**EMERGENCY CONTACTS TO BE USED WHEN PARENTS CANNOT BE REACHED:**

1. Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ Daytime phone/cell phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ Daytime phone/cell phone \_\_\_\_\_

**PHYSICIAN'S NAME** \_\_\_\_\_ **Phone number** \_\_\_\_\_

**Preferred Hospital for Emergency Care** \_\_\_\_\_

**For those EMERGENCIES requiring immediate medical attention, you child will be taken to the nearest hospital emergency room.**

**PLEASE LIST ANY PROBLEMS OR MEDICAL CONDITIONS (ALLERGIES, ETC.) WHICH MAY AFFECT YOUR CHILD'S LEARNING IN SCHOOL, CAUSE YOU ANY CONCERN AND/OR MAY BE IMPORTANT FOR SCHOOL STAFF TO KNOW.**

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

**I have reviewed all of this emergency information with my child.**

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Date**

