Location: 7504 Universal Blvd. Orlando 32819
Mailing address: P.O. Box 690282 Orlando, FL 32869
Phone: 407.354.3660 • Fax: 877.835.6090
www.JewishOrlando.com

Registration Form

2010-2011/ 5771

Please print clearly:

Part I: Student's Information

Last Name: _____First Name: _____ ☐ Male ☐ Female

Hebrew Name: _____Phone: _____ Child's e-mail: _____

Address: _____ Zip Code: _____

School: _____Grade: _____ Age: _____ Birthday: ___/___/___

Part II: Parents' Information

Father's Name: _____ Hebrew Name: _____

Mother's Name: _____Hebrew Name: _____

Home phone: _____ Fax: _____ e-mail: _____

Work # (Father): _____ Cell # (Father): _____

Work # (Mother): _____ Cell # (Mother): _____

Synagogue (*if any*): _____

Part III: Hebrew Education

Does your child read Hebrew? ☐ None ☐ Somewhat ☐ Well

Does your child speak/understand Hebrew? ☐ None ☐ Somewhat ☐ Well

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

If yes, please describe: _____

Child's previous Hebrew education (*if any*): _____

Were there any conversions and/or adoptions in the immediate or extended family?

_____

If yes, please explain: _____

Is anyone in the family a Kohen or Levi? _____

If yes, please explain: _____

...A link to the past...A bridge to the future!

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Part IV: Tuition

Please check the program you would like your child to attend:

☐ Hebrew school: Sunday 10:00 A.M - 12:30 P.M. @ $570 per year*

☐ Chai Teens: every other Thursday 4:30 P.M. – 6:15 P.M. @ $250 per year*

* Price includes $30 for Lunches on extended Sundays, (See HS Calendar)

Add $30 Registration Fee (Waived when Paying in full).

Please take off 10% for each additional sibling.

Please check your choice for method of payment:

☐ Full payment enclosed

☐ Four post-dated payments Sept/1/10, Nov/1/10, Jan/1/11 and March/01/11 $150 each ($136.50 for a 2nd child)

Please make checks payable to Chabad of South Orlando.

Name: _____Visa/MC/Amex #: _____

Exp. Date: ____ /____/____ CCV Code *(last 3 digits of # on back of card strip)*: _____ Billing Zip Code: _____ Amount: $_____ Signature: _____

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Part V: Medical Information *(confidential)*

Family physician: _____ Phone: _____

Up to date with vaccinations? ☐ Yes ☐ No

Is there any medical or other information (allergies, etc.) regarding your child that our school should be aware of? _____

_____

Person to be contacted in case of an emergency (when parents cannot be reached):

Name: _____ Phone #: _____

Relationship to child: _____

Medical Release Form:

I hereby consent to the administration of Chabad Hebrew School to take whatever medical measures they deem necessary for my child in the event of a medical emergency.

Signature of Parent or Guardian: _____ Date: _____

If your child is a 1st time student at Chabad, please call to schedule a meeting with the Director, after submitting this form. Thank You.