

NEVE SHALOM HEBREW SCHOOL STUDENT REGISTRATION FORM 2010/2011

Student's Name _____ Home Phone _____

Last First (Mark * If you do not wish to be listed in the school directory)

Address _____ Birthdate _____

City _____ ZIP _____ Synagogue Member: ___ Yes ___ No

P.S. Grade in Sept. _____ School Name _____

Student's Hebrew Name _____ You have permission to use my child's photo

Mother's Name _____ Father's Name _____

Mother's Cell No. _____ Father's Cell No. _____

*Mark * if this is a new email or you have not been receiving School email reminders*

Mother's Email _____ Father's Email _____

Work No. _____ Work No. _____

BOOK & MATERIALS FEES
(PAID AT TIME OF REGISTRATION):

TUITION
(Due in September or on payment plan)

	MEMBER	NON-MEMBER	MEMBER	NON-MEMBER
Gan & 1 st grades	\$70	\$90	\$525	\$775
2 nd grade	\$110	\$125	\$625	\$850
3 rd -7 th grades	\$110	\$125	\$825	\$2,250
8 th -10 th grades	\$45	\$45	\$425	\$425
11 th -12 th grades	\$25	\$25	\$175	\$175

Please register my child in: ___ GAN, ___ KEN (1st gr.), ___ KITA KTANA (2nd gr.), ___ ALEPH (3rd gr.),
 ___ BET (4th gr.), ___ GIMEL (5th gr.), ___ DALED (6th gr.), ___ HAI (7th gr.),
 ___ 8th grade ___ 9th grade ___ 10th grade ___ 11th-12th grade

___ Please charge my credit card \$ _____ (info on following page) ___ Enclosed is a check for \$ _____

___ I will pay tuition in full by Sept. 1
 ___ I will pay tuition in three installments (Sept., Nov., Feb.)
 ___ Please bill tuition monthly (Sept. – May_)

Signature _____ Date _____

Gan and Ken classes meets Sundays 9-11am **Kita K'tana** meets Sundays 9-11am and Tuesdays 4:15-6pm
Aleph-Daled meet Sundays 9-11am, Tues. & Thurs 4:15-6pm **Hai** meets Tues. 5:45-8:30pm, Thurs. 5:45-7:30pm
8th-10th grades meet Tuesdays 6-8:30pm **11-12th** grades meet monthly on Sunday 11am-noon

MEDICAL RELEASE CARD – NEVE SHALOM, METUCHEN, NJ – 2010-2011

Child's Name _____ Birthdate _____

Address _____ Phone # _____

City _____ **ZIP** _____

Mother's Name _____ Father's Name _____

Work No. _____ Work No. _____

Cell No. _____ Cell No. _____

Emergency Contact and Telephone No. _____

Child's Doctor _____ Phone # _____

In case none of the above can be reached, or it is imperative to treat the child without delay, I hereby give permission to the School Administration to take my child to the nearest hospital for medical treatment.

Parent Signature _____ Date _____

Allergies to the following medicine(s): _____

Allergies to the following foods: _____

Identified learning or behavioral issues: _____

Does your child have an IEP? ___Yes ___No (*If yes, please give a copy to the Educational Director*)

CREDIT CARD INFO:

Name on Card _____ **___ Visa ___ MC**

Card # _ _ _ - _ _ _ - _ _ _ - _ _ _ **Expiration Date** _ _ / _ _

Amount to place on card \$ _____