



**SINAI TEMPLE RELIGIOUS SCHOOL**  
**2010-2011/5770-5771 School Year Registration Form**

**Student's Name:** \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Child's Hebrew Name:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Religious School: \_\_\_\_\_ Hebrew School: \_\_\_\_\_

Secular School: \_\_\_\_\_ Grade as of September 2009: \_\_\_\_\_

**Student's Email Address:** \_\_\_\_\_

**Parent(s)/Guardian(s):**

1. Parent/Guardian: \_\_\_\_\_

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

**Email:** \_\_\_\_\_

Receive e-mail updates to this address? **Yes** \_\_\_ **No** \_\_\_

2. Parent/Guardian: \_\_\_\_\_

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

**Email:** \_\_\_\_\_

Receive e-mail updates to this address? **Yes** \_\_\_ **No** \_\_\_

*Address if different than above:* \_\_\_\_\_

*City/State/Zip:* \_\_\_\_\_

**Include mailings to this address?** **Yes** \_\_\_ **No** \_\_\_

Student lives with:  Both  Parent/Guardian 1  Parent/Guardian 2 Other: \_\_\_\_\_

**CHILD'S INTERESTS:**

\_\_\_\_\_ is interested in participating in the following activities:

- |  |   |
|--|---|
| ___ Art  | ___ Music: General                      |
| ___ Music: Learning song leading   | ___ Music: Playing an instrument        |
| ___ Sports   | ___ Drama                               |
| ___ Working with younger children  | ___ Participating in mitzvah projects   |
| ___ Conversational Hebrew  | ___ Participating in overnight programs |
| ___ Becoming a Jewish ambassador: talking to non-Jewish kids about Judaism         |   |
| ___ Becoming a Holocaust ambassador: talking in public schools about the Holocaust |   |
| ___ Other _____  |   |

**Please Return this form to Sinai Temple Religious School**  
**3104 West Windsor Road, Champaign, IL 61822**  
**Phone: 217-352-8654 Fax: 217-352-8304**



**SINAI TEMPLE RELIGIOUS SCHOOL**  
**2010-2011/5770-5771 School Year Registration Form, cont.**

In case of injury or illness of a student at school, every effort will be made to contact the parent or guardian. The following instructions will remain in force unless revoked by parent or guardian:

IF INJURY OR ILLNESS IS **MINOR**, GIVE CHILD FIRST AID? YES \_\_\_\_ NO \_\_\_\_

← Check One

***In the event of a medical emergency, I authorize the staff to obtain emergency medical treatment for my child. I understand that I will be contacted immediately, as will my physician.***

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Room Preference: Carle Hospital / Provena Hospital (Circle One)

← Circle One

→ Sign Here

_____ <small>PARENT/GUARDIAN'S NAME (Please Print)</small>	_____ <small>PARENT/GUARDIAN'S SIGNATURE</small>	_____ <small>DATE</small>
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**EMERGENCY CONTACT:**

NAME: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

*\*\*Will be contacted only after attempts to contact the parent have been unsuccessful.\*\**

**TO BEST MEET THE NEEDS OF EACH STUDENT, PLEASE TELL US ABOUT YOUR CHILD AND ANY SPECIAL NEEDS. Attach an additional sheet if necessary.**

Does your child have any physical or medical concerns to which the school should pay attention?  
 Yes  No

Please explain: \_\_\_\_\_  
 \_\_\_\_\_

Does your child carry any medical aids such as inhalers or Epipens?  
 Yes  No

Please explain: \_\_\_\_\_  
 \_\_\_\_\_

Does your child have any vision or hearing impairments that may affect his or her classroom participation?  
 Yes  No

Please explain: \_\_\_\_\_  
 \_\_\_\_\_

Are there any educational, personal, or family situations that may affect your child's attention span and school performance? *(If yes, you may wish to schedule a meeting with the Ed Dir prior to the first day.)*

Yes  No  
 Please explain: \_\_\_\_\_  
 \_\_\_\_\_

Does your child have any food allergies?  
 Yes  No

Please explain: \_\_\_\_\_  
 \_\_\_\_\_

Additional Information: \_\_\_\_\_  
 \_\_\_\_\_

Is your child affected by exercise-related difficulties such as asthma?  
 Yes  No

Please explain: \_\_\_\_\_