

**THE DOWNTOWN SYNAGOGUE HEBREW SCHOOL REGISTRATION/MEDICAL
INFORMATION 2004-2005**

THIS FORM MUST BE RETURNED WITH YOUR CHECK

STUDENT NAME _____ BIRTH DATE _____

EXACT AGE (as of 9-04) _____

HOME ADDRESS

FATHER _____ BUSINESS PHONE _____ CELL/PAGER _____

MOTHER _____ BUSINESS PHONE _____ CELL/PAGER _____

E-MAIL ADDRESS _____

In an emergency when family cannot be reached, one of the following will come for my child:

NAME _____ PHONE _____

NAME _____ PHONE _____

FAMILY PHYSICIAN _____ PHONE _____

DAY SCHOOL CHILD ATTENDS (as of 9-04) _____ GRADE (as of 9-04) _____

CURRENT HEALTH INFORMATION:

Please describe any health issues we should know about:

ALLERGIES: _____

Is student currently taking any medications: If so, what? _____

In the case of an emergency, I hereby give my permission to the accompanying adult to take my child _____ to the Emergency Room of the nearest hospital in the event that I cannot be reached at any given number and that all necessary treatment can be given at that time.

(signature of parent)

I would like my correspondence addressed as follows: _____

Additional information may be added.

Please return this form to The Downtown Synagogue, P.O. Box 1336, Church St. Station, New York, NY 10008