PLEASANTVILLE COMMUNITY SYNAGOGUE

**RELIGIOUS SCHOOL REGISTRATION 2014-2015**

*~ Please print clearly or type ~*

Child's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hebrew Name *(if known)* \_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_ Grade as of September 2014 \_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School District \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent 1: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Volunteer to be Class Parent

[ ]  Volunteer to help at class and school events

Parent 2: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Volunteer to be Class Parent

[ ]  Volunteer to help at class and school events

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASANTVILLE COMMUNITY SYNAGOGUE

**RELIGIOUS SCHOOL STUDENT INFORMATION FORM**

**2014-2015**

*~ Please print clearly or type ~*

We strive to create a positive learning experience for all of our students. In order for us to

achieve this goal, it is helpful to understand your child’s specific learning style. Please complete

this profile and return it with your registration form to the Education Office. In addition, we

welcome the opportunity to meet with you (and your child) to assure the best learning

environment possible at the PCS Hebrew School.

STUDENT’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GRADE \_\_\_\_\_\_DATE COMPLETED \_\_\_\_\_\_\_\_

*\** **Confidential Student Profile** \* *This form will be used for educational planning purposes only. Its contents will be viewed only by your child’s principal, teacher(s), and/or providers of special education services.*

1. Does your child have an Individual Education Plan (IEP), 504 Plan, OHD – Other Health Disability Plan, or other educational plan from the public school district?

 □ Yes □ No

2. Does your child have a private school-generated education plan providing modifications? □ Yes □ No

 *\*If yes to questions 1 or 2, please attach a copy of your child’s current educational plan (IEP, 504, or OHD) to this form, if desired.*

3. Does your child receive support services in or out of their school day (special education / resource support, paraprofessional, one-on-one aide, private therapist, private tutor)?

 □ Yes □ No

*If so, provide details:*

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

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4. Was a referral for assessment of concerns at school recently made or is one in progress?

 □ Yes □ No

*If yes, please explain:*

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

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5. Does your child take medication? If yes, provide names of medication(s) and, if needed during school hours, the times administered. □ Yes □ No

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

6. Does your child have any special needs that would affect his/her choice of seating location? Please explain.

 □ Vision □ Speech □ Hearing □ Distractibility

 □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Are there any chronic or specific health concerns of which we should be aware? (i.e. seizures, asthma, diabetes, migraines, etc.) □ No □ Yes

 If yes, please identify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Does your child have allergies to any of the following? If yes, please identify:

□ Food \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Insects \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Other information regarding your child’s health or education that you would like to share:

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

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 *(feel free to add an additional piece of paper for more room in response to any of the questions)*

10. Would you like us to contact you to discuss this information further?

 □ Yes □ No

 Please give instructions in the event that you are unavailable in case of an emergency:

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

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Name and relationship to child of person completing this form:

Print name Relationship to Child Signature