



Chabad Hebrew School

ב"ה

3031 Quadra Street Victoria BC V8T 4G2
250-385-7656 • www.chabadvi.org • preschool@chabadvi.org
Mailing Address: 3107 Aldridge Street Victoria BC V8P 4L5

Registration Application 2010-2011

Please Print Clearly

Part I: Student Information

Last Name _____ First Name _____

Hebrew Name _____ Date of Birth _____ Approx. time of birth* _____

Address _____ City _____ Postcode _____ Phone _____

Age _____ Grade (Entering) _____ School _____

*Necessary in order to determine Hebrew birthday

Student 2

Last Name _____ First Name _____

Hebrew Name _____ Date of Birth _____ Approx. time of birth* _____

Age _____ Grade (Entering) _____ School _____

*Necessary in order to determine Hebrew birthday

Part II: Parents' Information

Father's Name _____ Hebrew Name _____

Work Address _____ Phone _____ Occupation _____

Mother's Name _____ Hebrew Name _____

Work Address _____ Phone _____ Occupation _____

e-mail (parent) _____

Father's Cell # _____ Mother's Cell # _____

Part III: Religious & Educational History

Previous Hebrew Education _____

Does your child read basic Hebrew? None Somewhat Well

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

If Yes, please describe. _____

Were there any conversions or adoptions in the family? _____

If Yes, please explain. _____



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Part IV: Medical Information (confidential)

Up to date with vaccinations? Yes No

Are there any special medical or other information, which we should be aware of? (Will remain confidential) _____

Signature _____

Date _____

Permission/release

I hereby permit my child _____ to participate in all school activities and to join in class and school trips on and beyond school properties and use any transportation selected by the Chabad Hebrew School.

Signature of parent _____

Date _____

Emergency Contact Information

Persons to be contacted in case of an emergency when parents cannot be reached:

Name 1 _____ Telephone # () - _____

Relationship to child _____ City/Town _____

Name 2 _____ Telephone # () - _____

Relationship to child _____ City/Town _____

Family Physician _____ Telephone # () - _____

Care Card Number _____



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Medical Release Form

I hereby give my consent to the administration of the Chabad Hebrew School to take whatever medical measures they deem necessary, at my expense, for my child in the event of a medical emergency. I will not hold them responsible for their decisions.

Signature of parent _____

Date _____

I am enclosing the following to cover the cost of Chabad Hebrew School per child:

- Tuition Fee: \$500 (Please check box with your choice for method of payment)
 - Ten postdated cheques of \$50.00 each, dated the first of every month September-June
 - A single payment of \$500
- Book Fee: \$15

Please let us know if you are interested in:

___ Private after school lessons

___ Bar/Bat Mitzvah Preparations

___ Information on adult education

Signature _____

Date _____

We look forward to an exciting fun time with your child - here at Chabad Hebrew School.