BETH TORAH
SCHECK FAMILY
RELIGIOUS SCHOOL

SCHECK FAMILY RELIGIOUS SCHOOL
OFFICE INFORMATION FORM

Child's Last Name:_____ First Name:_____ Sex: M _____ F _____

Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Mother or Guardian's

Full Name: _____

Work #: _____

Cellular #: _____

E-mail: _____

Father or Guardian's

Full Name: _____

Work #: _____

Cellular #: _____

E-mail: _____

People authorized to pick up my child:

NAME **PHONE NUMBER** **RELATIONSHIP**

_____

_____

_____

People **Not Permitted** To Pick Up:

_____

_____

Carpool Arrangement: Please complete which other Family will Pick Up your child/ren every Wednesday

_____

_____

Pediatrician's Name: _____ Phone #: _____

Other people to be notified in case of illness or accident:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

May Scheck Family Religious School contact another physician if unable to contact yours?

Yes: _____ No: _____

_____ _____

Parent or Guardian(s) Signature Date