

TEMPLE EMEK SHALOM  
SHUL SCHOOL REGISTRATION FORM 2016-2017

Child's Name

Date of Birth

Grade

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Mother's Name \_\_\_\_\_ Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cel Phone \_\_\_\_\_ Email \_\_\_\_\_

Father's Name \_\_\_\_\_ Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cel Phone \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Cel Phone \_\_\_\_\_

Does your child have any allergies or take any medications that we should know about?

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Is there anything about your child that you want us to know about?

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