

Re-Registration Form

School Year _____

Cincinnati Hebrew Day School

Sam and Rachel Boymel Campus
2222 Losantiville Rd.
Cincinnati, Ohio 45237

Phone: (513) 351-7777

Fax: (513) 351-7794

Student Name _____

Last

First

Middle

Hebrew Name

Middle

First

Address _____

City _____ State _____ Zip _____

English Birth Date: _____

Home phone: _____ Mother's cell: _____ Father's cell: _____

E-mail address _____

Father's Daytime Telephone No. _____

Mother's Daytime Telephone No. _____

Emergency Phone No. / Name _____

Registration is for: (check appropriate program)

_____ Pre-kindergarten (four year old program)

_____ Kindergarten

_____ Grades 1-8 (note grade)

Special Information to be brought to the school's attention (learning problems, allergies-food or others, medications, etc.) If medication is to be dispensed on a daily basis, doctor's orders must be submitted to the school.

Annual Medical Forms Are Required By The State Of Ohio Before Any Student May Attend School (See Attached Physician's Form)

I understand that my registration is only complete with a copy of my child's updated shot record enclosed.

Date: _____ Signature of Parent or Guardian: _____

Cincinnati Hebrew Day School
2222 Losantiville Road
Cincinnati, Ohio 45237
(513) 3512-7777
(513) 351-7794 (fax)

**PARENTS PERMISSION FOR THE ADMINISTRATION OF NON-
PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL**

NAME OF CHILD: _____

Name of non-prescription medication to be given: _____

Dosage: _____

At following time(s): _____

Special Instructions: _____

_____ I do not want school personnel to give my child, _____
any non-prescription medication.

_____ I hereby request and give my permission to the principal or his/her
delegate (school secretary or other responsible person) to administer non-
prescription medication to my child. (Children's or junior Tylenol, cough
drops, or non-prescription medication brought in with a note from parent).

**I understand and acknowledge that school personnel are under no obligation to
render the assistance requested, and that such assistance may, in the absence of a
school nurse, be rendered by an employee of the school who is not medically trained.
I hereby release the Cincinnati Hebrew Day School, its Board of Directors, its
officials and employees including the Principal and his/her delegate from any and
all liability for damages or injury directly or indirectly resulting from the
performance or failure of performance of the assistance requested.**

Date

Parent or Guardian Signature

**Cincinnati Hebrew Day School
Blanket Field Trip Form 2010/11 School Year**

Dear Parents:

In anticipation of a year of exciting field trips, we are asking if you would sign the general permission form below. This blanket permission slip will suffice as your permission for all field trips in the Cincinnati area during the 2010-2011 school year.

We will be notifying you of upcoming field trips with notes.

Please sign the permission form and return it to school by the first day of school.

Sincerely,

Rabbi Kernerman,
Principal

I, _____, give permission for _____
(Parent/Guardian) (Student)

to go on any local field trip during the 2010-2011 school year by either school bus or private vehicle.

Signed: _____
(Signature of Parent/Guardian) (Date)

EMERGENCY MEDICAL AUTHORIZATION

Cincinnati Hebrew Day School
(513) 351-7777 (513) 351-7794 (fax)

Student Name _____ Home phone: _____

Work Phone: _____ (father) _____ (mother)

Purpose of this form - To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

Part I (TO GRANT REQUEST)

In the event that the school was unable to contact me at the above numbers, I hereby give my consent for:

(1) The administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.

Doctor Address: _____ Doctor Phone # _____

Dentist Address: _____ Dentist Phone # _____

(2) The transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Please note important facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

DATE

SIGNATURE OF PARENT

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

Part II (REFUSAL TO CONSENT)

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the school authorities to take no action.

DATE

SIGNATURE OF PARENT: