



# CHAICENTRAL

## Bar & Bat Mitzvah Prep School

A Project of Chabad of East Brunswick  
School Location: Churchill Junior High School

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P.O. Box 6362·East Brunswick, NJ 08816

732·333·3220 · www.ebChabad.com

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### **Student Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Hebrew Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

(No prior Hebrew School or Hebrew language experience required)

Does your child read basic Hebrew?  None  Somewhat  Well

Does your child have previous Jewish Education?  Yes  No

If yes, please describe:

\_\_\_\_\_

What school does your child attend? \_\_\_\_\_ Grade Entering: \_\_\_\_\_

Synagogue affiliated with: \_\_\_\_\_

Were there any conversions or adoptions in your family?  Yes  No

If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any considerations, such as learning disorder or difficulty, the school should be aware of? (*Confidential*):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Parent Information**

Father's Name: \_\_\_\_\_ Father's Hebrew Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Mother's Hebrew Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: (if different) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Family Background**

Jewish Name                      Native Religion

**Mother's Side**

Maternal Grandmother \_\_\_\_\_

Maternal Grandfather \_\_\_\_\_

**Father's Side**

Paternal Grandmother \_\_\_\_\_

Paternal Grandfather \_\_\_\_\_

**Emergency Contact Information**

Please list two contacts to be used in case of emergencies (other than your home and business numbers).

| Name     | Relationship to Child(ren) | Phone Number |
|----------|----------------------------|--------------|
| 1) _____ |                            |              |
| 2) _____ |                            |              |

Child(ren)'s physician or medical facility: \_\_\_\_\_ Phone: \_\_\_\_\_  
Physician's address: \_\_\_\_\_  
Health Insurance: \_\_\_\_\_ Group #: \_\_\_\_\_ ID#: \_\_\_\_\_





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### **Student Information – 2<sup>nd</sup> CHILD**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Hebrew Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

(No prior Hebrew School or Hebrew language experience required)

Does your child read basic Hebrew?  None  Somewhat  Well

Does your child have previous Jewish Education?  Yes  No

If yes, please describe:

\_\_\_\_\_

What school does your child attend? \_\_\_\_\_ Grade Entering: \_\_\_\_\_

Were there any conversions or adoptions in your family?  Yes  No

If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CONFIDENTIAL: Any considerations, such as learning disorder or difficulty, the school should be aware of?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CONFIDENTIAL: Does your child have any allergies or other medical condition we should be aware of? If yes, please describe them and indicate special precautions or care needed.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_