



**High School @Akiva**  
 26500 Shaker Blvd  
 Beachwood, Ohio 44122  
 216-464-4050  
[akiva@siegalcollege.edu](mailto:akiva@siegalcollege.edu)  
**Registration Form**  
 2011/12

STUDENT'S NAME \_\_\_\_\_ STUDENT'S E-MAIL ADDRESS \_\_\_\_\_

HEBREW NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ STUDENT CELL PHONE \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

SECULAR SCHOOL \_\_\_\_\_ GRADE AS OF 9/11 \_\_\_\_\_

SUPPLEMENTAL OR DAY SCHOOL LAST ATTENDED \_\_\_\_\_

SYNAGOGUE AFFILIATION \_\_\_\_\_ YOUTH GROUP AFFILIATION \_\_\_\_\_

**FATHER**

**MOTHER**

DR  
 MR

DR  
 MRS  
 MS

E-MAIL ADDRESS \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ CITY \_\_\_\_\_

PHONE \_\_\_\_\_ PHONE \_\_\_\_\_

CELL PHONE (DAY) (EVENING) \_\_\_\_\_ CELL PHONE (DAY) (EVENING) \_\_\_\_\_

IN CASE OF EMERGENCY, PERSON (OTHER THAN PARENTS) TO CONTACT  
 NAME \_\_\_\_\_ PHONE \_\_\_\_\_

I AM REGISTERING FOR

- HEBREW EXPLORERS
  - High School credit requested
- JEWISH EXPLORERS
  - Monday
  - Tuesday - Beit Midrash
  - Thursday - Torah High
  - Sunday – Tikun Olam
- College Credit information requested

**PLEASE SEND FINANCIAL AID INFORMATION**  
**RETURN THIS FORM WITH A \$200 DEPOSIT**  
**Complete the reverse side**

**2011-2012 Tuition**

2 Days Per Week	\$825.00
2 <sup>nd</sup> student in family	\$725.00
1 Day Per Week	\$450.00

No charge for Sunday or Monday classes for those students enrolled 2 days per week.

**HS@AKIVA Emergency Medical Authorization**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Please describe any special learning concerns or considerations which @Akiva faculty should be made aware.

\_\_\_\_\_

**Part I or II Must Be Completed**

**Part I Granting Consent**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone Number \_\_\_\_\_

Local Hospital \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-name doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to 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 prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medication being taken, and any physical impairments to which a physician should be alerted: \_\_\_\_\_

\_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**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 emergency treatment, I wish the school authorities to take the following action:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_