

LIVING TORAH CENTER/CHABAD
CHABAD HEBREW SCHOOL
1341 9TH ST.
S. MONICA, CA 90401
310-394-5699
www.livingtorahcenter.com



APPLICATION FOR ENROLLMENT

Date: _____
Last Name: _____ Child’s Name: _____
Home Address: _____ City: _____ Zip _____
Home Phone () _____
Child’s Full Jewish Name: _____
Child’s Date of Birth: ____/____/____ Age: _____
School Attending: _____ Grade: _____

Father’s Name: _____
Father’s Full Jewish Name: _____
Father’s Cell Phone: () _____
Email: _____
Mothers Name: _____
Mother’s Full Jewish Name: _____
Mother’s Cell Phone: () _____
Email: _____

Is the child’s natural mother Jewish? _____
Are there any adoptions or conversions in the family? _____
If yes, please explain: _____

Contact person in case of emergency if we can not reach you:
1. Name _____ Relationship _____ Phone _____
2. Name _____ Relationship _____ Phone _____

Child’s Allergies:

Signature of Parent or Guardian

Date