Make *OurSpace*... Your Space

# 2019/20 ENROLLMENT FORM
# FOR PARTICIPANTS AGE 3-21

WWW.OURSPACELA.ORG

Date _____

PLEASE CHECK THE PROGRAMS THAT YOU WILL ATTEND

☐ SHAARE TIKVA ☐ MAKOM SHELI ☐ B'YACHAD BET ☐ KOLOT TIKVAH CHOIR ☐ ARTISTIC SPECTRUM

## STUDENT ☐ Male ☐ Female

First Name _____ Last Name _____ Hebrew Name _____

Date Of Birth _____ Student E-mail Address _____ Secular School- Grade _____

Address _____ City, State, Zip _____

Child Lives With: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian ☐ Other _____

Parents Are: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Parent responsible for tuition: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian ☐ Other _____

Will student's residence arrangements affect attendance? ☐ Yes ☐ No *(If yes, please explain)* _____

Siblings/Other Household Members (e.g., Step-parents, grandparents living with child) Please provide Name(s)/Relationship(s):

_____

## PARENT/LEGAL GUARDIAN 1

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.

First and Last Name _____

Relationship to child _____

Home Address _____

City, State, Zip _____

( ) Home Phone _____

( ) Cell Phone _____

E-mail Address _____

Profession _____

Business Address _____

City, State, Zip _____

( ) Business Phone _____

Are you a member of a Synagogue? ☐ Yes ☐ No

If yes, which one _____

## PARENT/LEGAL GUARDIAN 2

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.

First and Last Name _____

Relationship to child _____

Home Address _____

City, State, Zip _____

( ) Home Phone _____

( ) Cell Phone _____

E-mail Address _____

Profession _____

Business Address _____

City, State, Zip _____

( ) Business Phone _____

Are you a member of a Synagogue? ☐ Yes ☐ No

If yes, which one _____

## Jewish Education

Has your child previously attended a Jewish school or received private Jewish instruction? ☐Yes ☐No

If so provide the name of school or instructor _____

Does your child attend or belong to any Jewish youth programs? ☐Yes ☐No

If yes, which ones _____

_____

## Medical

Has your child been professionally evaluated? ☐Yes ☐No

If yes, what were the results and/or diagnoses (Please indicate below)

_____

_____

_____

Does your child have epilepsy/epileptic seizures? ☐Yes ☐No Are seizures under control? ☐Yes ☐No

Date of last seizure: _____ How are seizures being managed? _____

_____

Are there any past/present health concerns of which we should be aware? ☐Yes ☐No

If yes, please explain _____

_____

_____

Does your child have allergies? ☐Yes ☐No

If yes, please explain the allergies and possible reactions: _____

_____

Does your child have any food restrictions or a special diet? ☐Yes ☐No

If yes, please explain _____

_____

If your child is on a medication program, please complete:

Medication: _____

Specific Schedule: _____

Dosages: _____

Prescribing Physician/Psychiatrist: _____

Address _____ City, State, Zip _____ Phone _____

Prescribing Physician/Psychiatrist: _____

Address _____ City, State, Zip _____ Phone _____

Is your child currently receiving psychological therapy? ☐Yes ☐No

If yes, how frequently and what is the nature / reason for the therapy? _____

_____

Is your child receiving behavioral therapy? ☐Yes ☐No If yes, please explain the identified behavior(s) and plan

_____

_____

Do we need to implement these plans in our classes? ☐Yes ☐No

Is your child receiving speech therapy? ☐Yes ☐No If yes, please describe the reasons for this therapy and what strategies or tools are being used

_____

_____

I/We give permission to the professional staff of OurSpaceLA programs to speak with the physicians and/or therapists listed below in order to receive and release information regarding my child. ☐Yes ☐ No

If yes, your physician/therapist will need a release as well.

Please list the name(s) of the person(s) working with your child:

Name of Professional: _____

Address _____ City, State, Zip _____ Phone _____

Name of Professional: _____

Address _____ City, State, Zip _____ Phone _____

Is Regional Center providing services for your child ☐Yes ☐No. If yes, please include the name and contact information.

Service Coordinator_____ Phone _____

## Social/Behavior/Learning Style

What are your child's strengths?

_____

_____

What does your child love to do (e.g., hobbies, interests, passions)?

_____

_____

Does your child make friends easily? ☐Yes ☐No

Please comment _____

Is your child happier alone or with other children? ☐Alone ☐With other children

Please comment _____

Does your child get along with children of the same sex? ☐Yes ☐No

Please comment _____

Does your child get along with children of the opposite sex? ☐Yes ☐No

Please comment _____

Does your child follow instructions? ☐ Yes ☐ No

Please specify (e.g., a series of instructions)

Does your child need verbal and/or visual cues to learn? ☐ Yes ☐ No

Please comment

Does your child need a kinesthetic approach to help engage him/her in learning? ☐ Yes ☐ No

Please comment

Does your child have fine motor/gross motor difficulties? ☐ Yes ☐ No

If yes, please explain

Does your child have any fears and/or are there any situations that cause him/her anxiety? ☐ Yes ☐ No

If yes, please describe

What behaviors are exhibited as a result of these fears and anxieties?

What makes your child angry and how does he/she exhibit anger?

Does your child have any self-stimulating behaviors ? ☐ Yes ☐ No

If yes, please describe

Has your child exhibited aggressive behavior towards himself/herself or others? ☐ Yes ☐ No

If yes, please explain

Please comment about specific methods of intervention that are effective for your child. Please be specific so that we can use this information to create the best possible ***OurSpaceLA*** experience for your child.

Secular school now attending:

Address City, State, Zip Phone

Describe your child's program (i.e. special classes, resource room, etc.)

Grade level completed as of this June: _____

What does your child like best in school? _____

What does your child like least in school? _____

How do you feel the ***OurSpaceLA*** programs can best contribute to your child's development and to your whole family?

_____

_____

Attached please find copies of my child's I.E.P., psychological evaluation and/or any other assessments and evaluations that have been made. ☐ Yes ☐ No If no, please explain.

_____

## Student Release

### Medical Emergency Release:

In the event of a medical emergency, in accordance with the VBS OurSpaceLA's emergency procedure, I/we, the undersigned parent(s) or legal guardians of _____, a minor, do hereby release the appropriate personnel of VBS to either administer first aid OR release the child to an emergency hospital or disaster center, for further treatment, as they deem necessary. Furthermore, I/we authorize appropriate personnel of Valley Beth Shalom, to consent to all emergency medical care for this child to be rendered by a duly licensed physician, surgeon, dentist and/or other medical professional. This care may be given under whatever conditions are necessary to preserve the health and safety of the child. I/we further agree to pay all charges for that care and/or treatment. It is understood that if time and circumstances reasonably permit, VBS personnel will try, but are not required to communicate with me/us prior to such treatment.

Parent/Guardian 1 Signature: _____ Date: _____

Parent/Guardian 2 Signature: _____ Date: _____

Medical Insurance _____ ID # _____

Prescribing Physician _____ Phone (____) _____

Address _____ City, State, Zip _____

Life Sustaining Medication _____ Date of Last Tetanus Shot: _____

### Pick Up Release:

In accordance with the *OurSpace*LA emergency procedures, you are authorized to release my child to the following (when possible, list below contacts that are located within close proximity to the Valley Beth Shalom) :

| NAME/RELATIONSHIP | PHONE |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

OUT OF STATE CONTACT/RELATIONSHIP

| | |
|---|---|
| _____ | _____ |

## Photo/Audio/Video/Website Release:

I give permission for photographers, slides, video or audio tapes to be taken of my child to be used for our calendar, website, public relation purposes and the promotion of *OurSpace*LA programs. I understand that none of the above may be used by the mass media for newspaper or television stories without my consent for usage.

Parent/Guardian Signature: _____ Date: _____

## Directory Release:

I give my permission for my name, address, telephone number, and email address to be given to other parents in the *OurSpaceLA* programs at Valley Beth Shalom.

Parent/Guardian Signature: _____ Date: _____

## Field Trip Release:

○ I give permission and consent to *OurSpaceLA* and its employees and agents to take my child on field trips as part of the normal curriculum and program and, to the extent possible, absolve *OurSpaceLA*, Valley Beth Shalom and its employees and agents from any liability for personal injury to my child or property damage, except for injuries resulting from gross negligence of *OurSpaceLA*, Valley Beth Shalom, or their employees or agents.

I understand that for all field trips that require transportation, I will receive a permission slip. Unless I have signed the permission slip my child will not be permitted to go on the trip.

○ I do not give permission and consent to OurSpaceLa and its employees and agents to take my child on field trips.

Parent/Guardian Signature: _____ Date: _____

***Should any of the medical, emergency, or release information (including change of address or phone number) change within the duration of the school year it is your responsibility to inform the OurSpaceLA Administrative office in writing.***

# Tuition and Schedules

**Student's First and Last Name and Student's Grade Level** _____

**Parent's First and Last Name** _____

## OurSpace Education Programs

| | VBS Member | Non-Member |
|---|---|---|
| **Makom Sheli** (Grades K-7th)<br>(To be determined based on enrollment) | ☐ $872.00 | ☐ $990.00 |
| **Shaare Tikva** (ages 3-18)<br>Meets at Valley Beth Shalom on Sundays 9:15-11:30AM<br>Minimum of 3 students required | ☐ $872.00 | ☐ $990.00 |
| **ARTISTIC SPECTRUM** (ages 19-adult) | ☐ $1,120.00 | |

## *OURSPACELA SOCIAL GROUPS AND CHOIR*

**B'Yachad Bet** (ages 14-adult)
Meets at Valley Beth Shalom or designated venue one Sunday per month

| Membership | Covers membership and monthly events |
|---|---|
| ☐ $54.00 | ☐ $154.00 |

**Kolot Tikva Voices of Hope Choir (All Ages)**
Meets at Valley Beth Shalom 2 Sundays a month from 12:00-1:00PM
*In Additional to some Performance Dates*

☐ $180.00

**TOTAL AMOUNT ENCLOSED** $ _____

**PAYMENT PLANS**

- ○ **PAY IN FULL** - Enclosed please find my check or charge my credit card or debit card for the total balance due
- ○ **TWO EQUAL PAYMENTS** - Payments will be automatically charged to my credit card/withdrawn from my account on July 1, 2019 and September 1, 2019
- ○ **TEN EQUAL PAYMENTS** - Payments will be automatically charged to my credit card/withdrawn from my account on the 1st of each month July 2019-April 2020

**PAYMENT METHOD**

○ **DEBIT CARD #:**_____

**IMPORTANT: POST DATED CHECKS WILL NOT BE ACCEPTED**

○ **USE ATTACHED VOIDED CHECK FOR ECHECK (AUTO-PAY)** Account Type: ○ Checking ○ Savings

Routing Number_____ Account Number_____

○ **Credit Card**_____ Expires: _____ ○ Visa ○ Mastercard ○ Amex

Name on credit card: _____ CVV # : _____ ( 3-digit, # printed on the signature panel on the back of the card immediately following the last 4 numbers of your credit card number.)

Billing Address on this Card: _____ Zip Code: _____ Phone:_____

Signature: _____ Date: _____

OFFICE USE ONLY: Accounting _____ OurSpaceLA _____