



Soille San Diego Hebrew Day School

Application for Admission

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HOW DID YOU HEAR ABOUT OUR SCHOOL?

FOR OFFICE USE ONLY:

ACADEMIC YEAR: _____

DATE RECEIVED: _____

TUITION DEPOSIT: _____

RENWEB: _____

STUDENT INFORMATION: (PLEASE PRINT)

NAME: _____
(LAST) (FIRST) (FULL MIDDLE) (HEBREW NAME)

DATE OF BIRTH: _____ AGE: _____ GENDER: (CIRCLE ONE) M F CITIZEN OF: _____

APPLYING FOR: (CIRCLE ONE) INFANT TRANSITIONAL TODDLER PS 2-3 yrs PS 3-4 yrs PRE K K 1 2 3 4 5 6 7 8

PRESCHOOL APPLICANTS ONLY: (CIRCLE ALL THAT APPLY) 1/2 DAY FULL DAY 3 DAYS 5 DAYS
(3 DAY PROGRAM - SELECT YOUR DAYS) MON. TUES. WED. THUR. FRI.

PRESENT SCHOOL: _____ GRADE LEVEL: _____

OTHER SCHOOLS PREVIOUSLY ATTENDED: _____

CHECK IF APPROPRIATE: _____ FATHER DECEASED _____ PARENTS SEPERATED _____ ADOPTED, CHILD AWARE
_____ MOTHER DECEASED _____ PARENTS DIVORCED _____ ADOPTED, CHILD UNAWARE

STUDENT LIVES WITH: (CIRCLE ONE) PARENT GUARDIAN IF GUARDIAN, STATE RELATIONSHIP: _____

FULL NAMES OF SIBLINGS AND AGES: _____
(NAME) (AGE)

(NAME) (AGE)

(NAME) (AGE)



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STUDENT INFORMATION: (CONTINUED) _____
(APPLYING CHILD'S NAME)

PLEASE LIST NAME, YEAR OF GRADUATION, AND RELATIONSHIP OF ANY RELATIVES WHO ATTEND OR WHO HAVE ATTENDED SOILLE SAN DIEGO HEBREW DAY SCHOOL, SINCE 1963:

(NAME) (CLASS OF) (RELATIONSHIP TO APPLICANT) (EMAIL ADDRESS)

(NAME) (CLASS OF) (RELATIONSHIP TO APPLICANT) (EMAIL ADDRESS)

(NAME) (CLASS OF) (RELATIONSHIP TO APPLICANT) (EMAIL ADDRESS)

WHAT CONCERNS DO YOU HAVE REGARDING YOUR CHILD'S TRANSITION INTO OUR SCHOOL?

WHAT ARE YOU HOPING TO ACHIEVE BY ENROLLING AT SSDHDS?

WHAT ARE YOUR CHILD'S HOBBIES AND INTERESTS?

WHAT HOBBIES OR INTERESTS DOES YOUR CHILD PARTICIPATE IN OUTSIDE OF SCHOOL?

DOES YOUR CHILD HAVE AN IEP OR A PSYCHOEDUCATIONAL ASSESSMENT?(CIRCLE ONE) YES NO

PLEASE INDICATE THE NATURE OF ANY SPECIAL NEEDS OR LEARNING CHALLENGES:

PHONE (858) 279-3300
FAX (858) 279-3389
WEB SITE www.hebrewday.org

3630 Afton Road
San Diego, CA 92123



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FAMILY INFORMATION:

DO YOU WANT ADDITIONAL INFORMATION ABOUT TUITION ASSISTANCE? (CIRCLE ONE) YES NO

FATHER

TITLE: DR. MR. RABBI PROFESSOR

NAME: _____

HOME ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____

EMAIL: _____

COUNTRY OF BIRTH: _____

CITIZENSHIP: _____

LANGUAGE SPOKEN AT HOME: _____

CELL PHONE: _____

OCCUPATION: _____

COMPANY NAME: _____

BUSINESS ADDRESS: _____

BUSINESS PHONE: _____

ARE YOU JEWISH?(CIRCLE ONE) YES NO

FAMILY JEWISH PRACTICE: (CIRCLE ONE) ORTHODOX TRADITIONAL CONSERVATIVE REFORM RECONSTRUCTIONIST

SYNAGOGUE FAMILY ATTENDS: _____

MOTHER

TITLE: DR. MRS. MS. RABBI PROFESSOR

NAME: _____

HOME ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____

EMAIL: _____

COUNTRY OF BIRTH: _____

CITIZENSHIP: _____

LANGUAGE SPOKEN AT HOME: _____

CELL PHONE: _____

OCCUPATION: _____

COMPANY NAME: _____

BUSINESS ADDRESS: _____

BUSINESS PHONE: _____

ARE YOU JEWISH?(CIRCLE ONE) YES NO

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