בס"ד

New England Hebrew Academy
Lubavitz Yeshiva
9 Prescott St. Brookline, MA 02446
Phone (617) 731-5330 • **Fax** (617) 277-0752 • office@TheNEHA.com

PRESCHOOL REGISTRATION FORM

Registration For ☐**Toddler** ☐**Nursery** ☐**Pre-Kindergarten** ☐**Kindergarten** **In Sep. 20____**

Student Name:_____
Last First Middle

Hebrew Name:_____ Preferred Name:_____ ☐Male ☐Female

Home Address:_____
Street/Apt# City State Zip

Home Phone:_____ Date of Birth:_____ Hebrew Birthday:_____

Pediatrician's Name:_____ Phone:_____

Address:_____
Street/Apt# City State Zip

Emergency Contact Name:_____ Relationship to child_____

Phone Number:_____ Cell:_____

Address:_____
Street/Apt# City State Zip

Days Attending ☐5 Days ☐3 Days (Monday, Wednesday, Friday - Available in Toddler & Nursery only)
☐2 Days (Tuesday, Thursday - Available in Toddler & Nursery only)

Length of Day ☐8:30 am–12:30 pm(not available for Kindergarten) ☐8:30 am–2:00 pm ☐8:30 am-4:00pm

Early Arrival Group ☐ 7:30 am-8:30am (Available Monday through Friday)

Late Afternoon Group ☐ 4:00 pm-6:00 pm (Available Monday through Thursday)

School Previously attended_____

School Recommended by_____

Additional info/Comments:

_____

_____

_____

If you are registering more than one child you do not need to fill out page two more than once.

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Parents Info

☐ Mr. ☐ Dr. ☐ Rabbi

Father's Name: _____
Last First Middle

Home Address(If Different from student):_____
Street/Apt# City State Zip

Home Phone:_____ Cell#:_____ Work#:_____

Email:_____ Social Security#:____-___-____ Marital Status:_____

Occupation:_____ Employer Name:_____

☐ Ms. ☐ Mrs. ☐ Dr.

Mother's Name: _____
Last First Middle

Home Address(If Different from student):_____
Street/Apt# City State Zip

Home Phone:_____ Cell#:_____ Work#:_____

Email:_____ Social Security#:____-___-____ Marital Status:_____

Maiden Name_____

Occupation:_____ Employer Name:_____

Registration Fees: (Per Child)

☐ Before February 1 $250 ☐ After February 1 $350 ☐ After September 1 $450

I hereby register my child for the school term_____ 2015 ; to_____ 2016

Signature of Parent_____Date_____

Office use only
Registration Fee Paid:

Date_____Am't_____

1. AUTHORIZATION & CONSENT FORM

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child (full name) _____. However, if I cannot be reached, I herby authorize NEHA to transport my child to the _____ _____ Hospital (or Children's Hospital) and to secure for my child the necessary medical treatment.

I understand the teachers in the preschool are trained in Basic First Aid/CPR and I authorize them to give my child aid when appropriate.

_____ _____

Date **Parent Signature**

2. **Please sign and date the section below, even if no one else besides you will be picking up your child, so we know that you read this section, and didn't omit it accidentally.**

I authorize New England Hebrew Academy to release my child to the following persons (other than parents):

NAME: _____ TEL. NO. _____

RELATIONSHIP: _____

NAME: _____ TEL. NO. _____

RELATIONSHIP: _____

NAME: _____ TEL. NO. _____

RELATIONSHIP: _____

_____ _____

Date **Parent Signature**

3. **Allergies-Yes (list)_____ No_____**

   EpiPen- Yes_____ No_____

4. **Emergency Contact Information**
   Name & relationship to child-_____

   Phone number-_____

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth:_____
Medical History _____
_____

Pertinent Family History

Current Health Issues

Y	N	
☐	☐	Allergies: Please list: Medications _____ Food _____ Other _____
		History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No
☐	☐	Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)
☐	☐	Diabetes: ☐ Type I ☐ Type II
☐	☐	Seizure disorder: _____
☐	☐	Other (*Please specify)* _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:**_____

Hgt: _____(_____%) Wgt:_____(_____%) BMI: _____(_____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____	☐ Lungs _____	☐ Extremities _____
☐ Skin _____	☐ Heart _____	☐ Neurologic _____
☐ HEENT _____	☐ Abdomen _____	☐ Other _____
☐ Dental/Oral _____	☐ Genitalia _____	

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other_____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD: ____; Results: ____mm.
Referred for evaluation to: _____ ☐ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:_____

☐Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:**_____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 12/14/04*

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth: / / Sex: M F**

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		
	2		
	3		
	4		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		
	2		
	3		
	4		
	5		
	6		
	7		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib)	1		
	2		
	3		
	4		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1		
	2		
	3		
	4		
	5		
Pneumococcal Conjugate (e.g., PCV7, PCV13)	1		
	2		
	3		
	4		

Vaccine		Date	Vaccine Type
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2		
	3		
Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2		
Varicella (e.g., Var, MMRV)	1		
	2		
Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2		
Seasonal Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
	3		
	4		
H1N1 Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
Pneumococcal Polysaccharide (PPSV23)	1		
	2		
Hepatitis A (e.g., HepA, HepA-HepB)	1		
	2		
Human Papillomavirus (e.g., HPV quadrivalent, HPV bivalent,)	1		
	2		
	3		
Other:			

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)*: **Date: / /**

Signature:

Facility name: