Nessah Hebrew Academy Early Childhood Program

2017 – 2018 Enrollment Application

Child (Last, First): _____ *Gender* _____ *DOB*_____

Address: _____ *Home Ph:* _____

Mom: _____ *Cell:*_____ *Email:*_____

Dad: _____ *Cell:*_____ *Email:*_____

Preschool Tuition Package (includes Tuition and Hot Lunch)

2017-2018 School Year (10 months)

We are pleased to welcome children age 2 – 5 years old.

Full-day *$10,300 for the year* (***discounted*** *to $10,000 if paid by cash or check)*

Monday – Thursday *9:00am – 3:00pm*
Friday *9:00am – 2:00pm*

Half-day *$9,300 for the year* (***discounted*** *to $9,000 if paid by cash or check)*

Monday – Friday *9:00am –12:30pm*

Enrollment Fees (Non-refundable):

New Student: (Registration, Special Activities, PTA Fund and Earthquake Kit)	*$ 585*
Returning Student: (Registration, PTA Fund and Special Activities)	*$ 350*
All Students: 2017 Nessah membership fee for one parent (Age 25+)	*$ 300*

2017 Nessah Membership Fee:

As a condition of attending our Preschool, one parent is required to become a member of Nessah Educational and Cultural Center. The membership fee (Adult Age 25+) is $300 and includes one ticket to High Holiday Services. Please see the Discounts section regarding the purchase of a second membership.

Initial _____

Discounts (Note A):

*** Note A – Tuition packages already reduced through Financial Aid (see below) are not eligible for the sibling and prepayment discounts. However, all students are eligible for the tuition fee credit on the purchase of a second Nessah membership.*

Purchase of a Second Nessah Membership – a $100 preschool tuition fee credit will be provided upon the purchase of a second Age 25+ membership.

Sibling discount – a 5% discount is available on the regular full-day or half-day tuition package for the 2nd child.

Prepayment discount – if you pay the full tuition package in its entirety on or before September 28, 2017, a 5% discount will be provided.

Financial Assistance Requests:

Nessah Hebrew Academy provides a limited number of reduced-fee preschool tuition packages. If you want to apply for one of these packages, please submit a Financial Aid Application (with supporting documents) by May 10, 2017. Nessah will reply to you by May 30, 2017.

Extended Care:

Extended care is available:

Monday – Friday	*8:30 am – 9:00 am*	
Monday – Thursday	*3:00 pm – 3:30 pm*	*(afternoon not available on Fridays)*

Extended care tickets are sold in groups of 10 at a fee of $100.

One ticket is paid to Nessah upon drop-off (for morning) or upon pickup (for afternoon).

Initial _____

Payment Schedule and Policies:

With your application, you will provide either 10 equal, post-dated checks or complete a credit card charge authorization form (to be used for 10 equal charge installments).

[Note: Before the respective installment payment date, you can choose to pay by another payment method (cash or credit card). Upon receipt of your cash or credit card payment, your post-dated check will be returned to you].

First Month and Last Month (Non-refundable):

September 2017 - The first month of the school year is paid in advance on July 1, 2017 (or your credit card authorization is provided for July 1, 2017).

June 2018 – the last month of the school year is also paid in advance on August 1, 2017 (or your credit card authorization is provided for August 1, 2017).

Months October 2017 – May 2018:

Each of these 8 checks (or charge authorizations) should be dated the 1st of each month (October 1, November 1, December 1, etc.).

No adjustment for school absences:

Your tuition obligation is not reduced or recalculated due to sickness, vacation, holidays or any other times which the student has not attended the school.

Non-sufficient funds (NSF) fee for returned checks:

A $35 fee will be assessed by Nessah if your check is returned by your bank.

Suspension of school attendance due to non-payment:

If you are experiencing a financial circumstance in which you cannot complete your payment on the 1st, please speak with the Nessah accounting office. Note that nonpayment of your tuition installment is a breach of this contract. We, therefore, reserve the right to suspend your child's attendance or terminate the contract.

Initial _____

Hold Harmless and Indemnification Agreement:

We agree to release and hold harmless Nessah Hebrew Academy, its agents and employees from all claims, damages or other liabilities for injuries to our child(ren) which are not the result of gross negligence by this school, its agents or employees. We also agree to indemnify the school for damages by my child(ren).

Contract Agreement:

I understand and agree to all terms and policies of this contract.

Signature _____ *Date* _____

Printed Name _____

Thank you:

We appreciate the opportunity to teach your child and we welcome you to Nessah.

Initial _____

Nessah Hebrew Academy

CHILD'S INFORMATION

Child's Name: _____ Primary Language: _____

Child's Address: _____
Street City/Town Zip Code

Place of Birth: _____ Date of Birth: _____/_____/_____

Child's Schedule: MON _____ TUE _____ WED _____ THU _____ FRI _____

Parent/Guardian Information

Name:_____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

_____ _____

Home E-mail Address: _____ Home E-mail Address: _____

Cell Phone: _____ Cell Phone: _____

Home Phone: _____ Home Phone: _____

Others in Family Relationship: _____

Parent/Guardian Business Information

Company Name: _____ Company Name: _____

Address: _____ Address: _____

_____ _____

Business Phone: _____ Business Phone: _____

E-mail Address: _____ E-mail Address: _____

Medical Information

Eye Color: _____ Hair Color: _____ Height: _____ Weight: _____ Race: _____ Gender ☐M ☐F

Identified Allergies: _____

Identifying Marks: _____

Health Insurance Provider: _____

Physician/Dentist Information

Name of Physician/Clinic: _____ Phone: _____

Physician Address: _____
Street City/Town Zip Code

Date of Child's Last Physical : _____

Name of Dentist: _____ Phone: _____

Dentist Address: _____
Street City/Town Zip Code

Parent/Guardian Signature: _____ Date: _____

FOR CENTER USE: Center: _____ Date of Admission_____ Age of Admission: _____

Date Registration Fee Rec'd:_____ Director's Initials: _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER	STREET	CITY	STATE ZIP	BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only*)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (* *For infants and preschool-age children only*)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH_____
DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____ . This Child Care Center/School provides a program which extends from _____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician:_____ Date of Physical Exam: _____
Address:_____ Date This Form Completed: _____
Telephone: _____ Signature _____

☑ Physician ☑ Physician's Assistant ☑ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

This form is required for any child who has mild to severe allergies and must be completed by the child's parent/guardian and the child's physician.

Allergy Health Care Plan

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Allergen	**Treatment/Substitution**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Type of allergy transmission: ☐ Ingestion ☐ Contact ☐ Inhalation

Note: Do Not Depend on Antihistamines or Inhalers to treat a severe reaction. USE EPINEPHRINE.

Extremely Reactive to the Following Foods_____; therefore:

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**

☐ **If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.**

For the following signs of a *mild* allergic reaction administer: _____

_____

☐ **Skin:** Hives: Mild Itch

☐ **Nose:** Itchy, Runny, Sneezing

☐ **Stomach:** Mild Nausea/Discomfort

☐ **Mouth:** Itchy

☐ **Other:** _____

For any of the following signs of a *severe* allergic reaction or a combination of symptoms from different body areas, give Epinephrine and call 911. If prescribed and directed, give other medications (antihistamine/inhaler). Lay person flat. *If breathing is difficult or vomiting, place on side, or sit up.*

☐ **Mouth:** Significant Swelling of Tongue and/or Lips

☐ **Heart**: Pale, blue, faint, weak pulse, dizzy

☐ **Throat:** Tight, hoarse, trouble breathing/swallowing

☐ **Lungs:** Short of Breath

☐ **Skin:** Many hives over body, widespread redness

☐ **Stomach:** Repetitive vomiting, severe diarrhea

☐ **Other:** Feeling something bad is about to happen; anxiety, confusion

Other Medication Instructions: _____

_____

This form is required for any child who has mild to severe allergies and must be completed by the child's parent/guardian and the child's physician.

Prescribed Medications/Dosage:

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Potential Side Effects of Medication: _____

_____

Potential Consequences to Child if Treatment is Not Administered: _____

_____

Staff may be trained by: _____

The following staff have been trained on the child's medical condition:

_____ _____

_____ _____

_____ _____

Physician Signature: _____ Date: _____

Director/Principal: _____ Date: _____

Parent/Guardian Acknowledgement Statement

To ensure the safety of your child we cannot delete an allergy which has previously been documented unless we have a signed note from the child's physician stating that the child is no longer allergic to that item(s) and may now have that specific food(s); or be exposed to the item(s); nor can we add an item(s) or change a medication without a signed note from the child's physician.

I understand that Nessah requires the most up to date information regarding my child's allergy. I also understand that for the safety of my child, my child's photograph and allergy information will be posted in the classrooms and kitchen on the Allergy Awareness Chart.

Parent/Guardian Signature: _____ Date: _____

*****For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the *Authorization for Administration of Medication* form.

This plan must be updated annually or whenever there is any change in treatment or the child's condition changes.

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

ADDRESS

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: _____

   Licensing Office Address: _____

   Licensing Office Telephone #: _____

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS
(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

_____
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov

Rights of the Licensing Agency: Section 101200 (b) & (c)

The Department or Licensing Agency shall have the authority to interview children, or staff, and to inspect and audit child or facility records without prior consent. The licensee shall make provisions for private interviews with any children or staff members. The Department has the authority to inspect, audit, and copy child or child care center records upon demand during normal business hours. Records may be removed for copying if necessary.

_____

Child's Name

_____ _____

Parent/Guardian Signature Date

_____ _____

Center Director Signature Date

CALIFORNIA SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent record (cumulative folder) as defined in Section 49068 of the Education Code and shall transfer with that record. Local health departments shall have access to this record in schools, child care facilities, and family day care homes.

This record must be completed by school and child care personnel from an immunization record provided by parent or guardian. See reverse side for instructions.

Student Name _____ **Sex:** M ☐ F ☐ **Birthdate** _____ **Place of Birth** _____

Name of Parent or Guardian _____

Race/Ethnicity:
☐ White, not Hispanic
☐ Hispanic
☐ Black
☐ Other: _____

Address _____

Telephone _____ (Daytime) (Nighttime) **City** _____ **ZIP** _____

VACCINE	DATE EACH DOSE WAS GIVEN					
	1st	2nd	3rd	4th	5th	Booster
POLIO (OPV or IPV)						
DTP/DTaP/DT/Td (Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only)						
MMR (Measles, mumps, and rubella)						
HIB (Required only for child care and preschool)						
HEPATITIS B						
VARICELLA (Chickenpox)						
HEPATITIS A (Not required)						

TB SKIN TESTS	Type*	Date given	Date read	mm indur	Impression
	☐ PPD-Mantoux ☐ Other				☐ Pos ☐ Neg
	☐ PPD-Mantoux ☐ Other				☐ Pos ☐ Neg

*If required for school entry, must be Mantoux unless exception granted by local health department.

CHEST X-RAY (Necessary if skin test positive)

Film date: _____ Impression: ☐ normal ☐ abnormal

Person is free of communicable tuberculosis: ☐ yes ☐ no

I. DOCUMENTATION

I certify that I reviewed a record of this child's immunizations and transcribed it accurately:

Date _____

Staff Signature _____

Record Presented was:
☐ Yellow California Immunization Record
☐ Out-of-state school record
☐ Other immunization record
Specify: _____

II. STATUS OF REQUIREMENTS

☐ A. All Requirements are met.
Date _____

☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

Exemption was granted for:
☐ C. Medical Reasons—Permanent
☐ D. Medical Reasons—Temporary
☐ E. Personal Beliefs

III. 7th GRADE ENTRY

☐ A. All Requirements are met.
Name _____ Date _____

☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.
Name _____ Date _____

INSTRUCTIONS FOR SCHOOL OR CHILD CARE STAFF

1. Complete child's name and address information section, or ask parent or guardian to complete this section only. (This form is not to be sent home or given to parents to complete.)
2. School or child care personnel then fill in date (month/day/year) of each immunization the student has received from the Immunization Record presented by the parent or guardian. (If the date consists only of month and year for some doses, fill in month/xx/year; however, if either measles, rubella or mumps (or MMR) was received in the month of the first birthday, month/day/year is required.)
3. Determine if immunization requirements have been met, using the California "Immunization Requirements for Grades K–12," or "Immunization Requirements for Child Care," (available from Immunization Coordinators in local health departments), or other requirements guide.
4. Complete the Documentation and Status of Requirements box.
   A. Fill in date and your signature as the staff member who reviewed and transcribed the immunization record presented by the parent or guardian. Check which type of record was presented.
   B. If the child has met all immunization requirements, check box A and write in date.
   C. If the child has not met all requirements, check box B. Child can be admitted only if up-to-date, e.g., no immunizations due currently. The child must be followed up as indicated in the "Guide to Immunization Requirements."
   D. If a child is to be exempted for medical reasons, a doctor's written statement is required; the statement must include which immunization(s) is to be exempted and the specific nature and probable duration of the medical condition. If the medical exemption is permanent, the requirement for the designated immunization(s) is met: check box A and box C.* If the medical exemption is temporary, check box B and box D; this child must be followed up.*
   E. If a child is to be exempted for reasons of personal beliefs, the parent or guardian must present documentation consistent with Health and Safety Code Section 120365, including documentation of all other required immunizations the child has received. All requirements are met; check box A and box E.*

Applicable only in those jurisdictions where the Tuberculosis Assessment is required for school entry

Personal Beliefs Affidavit to be Signed by Parent or Guardian—Tuberculosis

I hereby request exemption of the child named on the front from the tuberculosis assessment requirement for school/child care center entry because this procedure(s) is contrary to my beliefs. I understand that should there be cause to believe that my child is infected with active tuberculosis or should there be a tuberculosis outbreak, my child may be temporarily excluded from school.

Creencias Personales: Declaración Jurada Debe ser Firmada por el Padre o la Madre o el Guardián

Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para la evaluación de la tuberculosis (tisis) de la entrada a la escuela ya que esta evaluación es opuesta a mis creencias. Comprendo que si hay razón para sospechar que mi hijo sufra de la tuberculosis activa o si hay un brote de la tuberculosis, mi hijo puede ser excluido de la escuela.

Signature (Firma) _____ Date (Fecha) _____

* Names of all children who are exempt should be maintained on an exempt roster for immediate identification in case of disease outbreak in the community.

Nessah Hebrew Academy

Photograph and Video Release Permission Slip

As a parent or guardian of this student, I hereby consent to the use of photographs/videotape taken during the course of the school year for promotional and/or educational purposes (including Nessah News letter, Nessah Website, Nessah social media). I do this with full knowledge and consent and waive all claims for compensation for use, or for damages.

Yes, I give consent for Nessah Hebrew Academy to photograph or video tape my child for school purposes and/or at school events.

Parent Signature: _____ Date: _____

Student's Name: _____