SHALOM SCHOOL 2026-2027
FAMILY INFORMATION AND EMERGENCY FORM

CHILD(REN)'S LAST NAME: _____

STUDENT INFORMATION:

Name	Gender	Date of Birth	Class/Grade

PARENT/GUARDIAN INFORMATION:

Name:		
Relationship:		
Email:		
Phone:		
Alternate Phone:		
Address:		
City, State, Zip:		
Employer/Occupation:		
Lives with child?	☐ YES	☐ NO

Name:		
Relationship:		
Email:		
Phone:		
Alternate Phone:		
Address:		
City, State, Zip:		
Employer/Occupation:		
Lives with child?	☐ YES	☐ NO

WHICH BRANCH OF JUDAISM DO YOU PRACTICE? (CONSERVATIVE, REFORM, CHABAD, ETC.) _____

IF YOU ARE AFFILIATED WITH A CONGREGATION, PLEASE INDICATE NAME: _____

GRANDPARENT INFORMATION: Used for invitations to special events, sharing school information, and solicitations.

Name:	
Email:	
Phone:	
Address:	
City, State, Zip:	

Name:	
Email:	
Phone:	
Address:	
City, State, Zip:	

EMERGENCY CONTACTS: The following persons are authorized to be contacted if parents/guardians are unavailable.

Name	Phone	Relation	Authorized to pick up?

AUTHORIZED DRIVERS: The following persons are authorized to pick up or transport students listed above.

Name	Phone	Relation

MEDICAL AND INSURANCE INFORMATION:

Hospital Preference:			
Insurance Name:		**Plan Number:**	
Physician's Name:		**Phone:**	
Dentist's Name:		**Phone:**	

STUDENT MEDICAL INFORMATION:

Name:

☐ Wears glasses or contacts ☐ Has a hearing problem ☐ Born before 37 weeks ☐ Asthma

☐ Seizures ☐ Heart Condition ☐ Diabetes ☐ Other (Please explain below)

☐ Child has a documented diagnosis/disability

☐ Child has a physical condition which limits participation in classroom activities or physical education

☐ Child has seen a professional to address mental/emotional/behavioral concerns in the past 12 months

☐ Child has received an educational evaluation/assessment by an outside professional

☐ Allergies: ______________________________

☐ Medications and Dosage: ______________________________

Please explain any of the above: ______________________________

____

☐ No known health problems

Name:

☐ Wears glasses or contacts ☐ Has a hearing problem ☐ Born before 37 weeks ☐ Asthma

☐ Seizures ☐ Heart Condition ☐ Diabetes ☐ Other (Please explain below)

☐ Child has a documented diagnosis/disability

☐ Child has a physical condition which limits participation in classroom activities or physical education

☐ Child has seen a professional to address mental/emotional/behavioral concerns in the past 12 months

☐ Child has received an educational evaluation/assessment by an outside professional

☐ Allergies: ______________________________

☐ Medications and Dosage: ______________________________

Please explain any of the above: ______________________________

____

☐ No known health problems

Name:

☐ Wears glasses or contacts ☐ Has a hearing problem ☐ Born before 37 weeks ☐ Asthma

☐ Seizures ☐ Heart Condition ☐ Diabetes ☐ Other (Please explain below)

☐ Child has a documented diagnosis/disability

☐ Child has a physical condition which limits participation in classroom activities or physical education

☐ Child has seen a professional to address mental/emotional/behavioral concerns in the past 12 months

☐ Child has received an educational evaluation/assessment by an outside professional

☐ Allergies: ______________________________

☐ Medications and Dosage: ______________________________

Please explain any of the above: ______________________________

____

☐ No known health problems

IMMUNIZATIONS:

Please submit a current copy of your child(ren)'s immunization record with this form.

In order to attend school or childcare, Shalom School requires that all children be up-to-date and fully immunized according to the requirements of the State of California Department of Public Health and the recommendations of the American Academy of Pediatrics and American Academy of Family Practice Physicians. Shalom School may exempt a child from any specific immunization requirement solely for medical reasons but only if the request is supported by a physician's verification of the specific medical reason. Shalom School will not exempt a child from any specific immunization requirement based upon religious or personal beliefs of a parent, guardian or student.
Please notify the office immediately if there is any change of information. All health and safety information is confidential and kept in a locked area.

MEDICATION CONSENT FORM:

If your child(ren) will be taking any over-the-counter or prescribed medications while at school, please complete the Parent/Physician Medication Consent Form and return it to the office.

AUTHORIZATION TO TREAT MINOR:

Should it become necessary for my/our child(ren) listed above to receive medical treatment while participating in any school related class, event, field trip, or activity, I/we hereby authorize the school staff to secure reasonable treatment including transportation for my/our child(ren). I/we do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care is considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services. This authorization is given in accordance with Section 4907 of the California Education Code and shall remain effective until revoked in writing and delivered to the principal or designee.

☐ I/we certify that I/we have read and understood this form and hereby give my/our authorization for emergency medical treatment, and that all of the information I/we have provided on this form is true and correct.
☐ I/we do not choose the above statement. I/we desire the following action to be taken in the event of an emergency

_____

_____

_____

Parent/Guardian 1 Signature: _____ Date: _____

Parent/Guardian 2 Signature: _____ Date: _____

STUDENT DEMOGRAPHIC INFORMATION

RACE AND ETHNICITY: Please check all that apply.

Student Name:	Student Name:	Student Name:
☐ **Black or African American**	☐ **Black or African American**	☐ **Black or African American**
☐ **American Indian or Alaskan Native**	☐ **American Indian or Alaskan Native**	☐ **American Indian or Alaskan Native**
☐ **Hispanic or Latino**	☐ **Hispanic or Latino**	☐ **Hispanic or Latino**
☐ **White**	☐ **White**	☐ **White**
☐ **Asian**	☐ **Asian**	☐ **Asian**
☐ Indian	☐ Indian	☐ Indian
☐ Cambodian	☐ Cambodian	☐ Cambodian
☐ Chinese	☐ Chinese	☐ Chinese
☐ Filipino	☐ Filipino	☐ Filipino
☐ Hmong	☐ Hmong	☐ Hmong
☐ Japanese	☐ Japanese	☐ Japanese
☐ Korean	☐ Korean	☐ Korean
☐ Laotian	☐ Laotian	☐ Laotian
☐ Vietnamese	☐ Vietnamese	☐ Vietnamese
☐ Other Asian	☐ Other Asian	☐ Other Asian
☐ **Pacific Islander**	☐ **Pacific Islander**	☐ **Pacific Islander**
☐ Guamanian	☐ Guamanian	☐ Guamanian
☐ Hawaiian	☐ Hawaiian	☐ Hawaiian
☐ Samoan	☐ Samoan	☐ Samoan
☐ Tahitian	☐ Tahitian	☐ Tahitian
☐ Other Pacific Islander	☐ Other Pacific Islander	☐ Other Pacific Islander

Please specify if the check boxes were insufficient: _____

LANGUAGE SPOKEN AT HOME:

Is a language other than English spoken at home? ☐ Yes ☐ No

What languages are spoken in the home? _____

PARENT/GUARDIAN EDUCATION LEVEL:

Parent/Guardian Name:	Parent/Guardian Name:
☐ No high school diploma	☐ No high school diploma
☐ High school degree or equivalent (e.g., GED)	☐ High school degree or equivalent (e.g., GED)
☐ Some college but no degree	☐ Some college but no degree
☐ Associate degree	☐ Associate degree
☐ Bachelor degree	☐ Bachelor degree
☐ Professional degree	☐ Professional degree
☐ Graduate degree	☐ Graduate degree
☐ Doctorate degree	☐ Doctorate degree

2026 – 2027 SHALOM SCHOOL
VEHICLE PARKING STICKER AND REGISTRATION FORM

Family Name:_____

License Plate Number:		
Signature:		
OFFICE USE		**FREE**
Sticker Number:	Date Received:	

License Plate Number:		
Signature:		
OFFICE USE		**FREE**
Sticker Number:	Date Received:	

License Plate Number:		
Signature:		
OFFICE USE		**$5.00**
Sticker Number:	Date Received:	

License Plate Number:		
Signature:		
OFFICE USE		**$5.00**
Sticker Number:	Date Received:	

License Plate Number:		
Signature:		
OFFICE USE		**$5.00**
Sticker Number:	Date Received:	

License Plate Number:		
Signature:		
OFFICE USE		**$5.00**
Sticker Number:	Date Received:	

State of California—Health and Human Services Agency

Department of Health Services
Child Health and Disability Prevention (CHDP) Program

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street	City	ZIP code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	/ /
Physical Examination	/ /
Dental Assessment	/ /
Nutritional Assessment	/ /
Developmental Assessment	/ /
Vision Screening	/ /
Audiometric (hearing) Screening	/ /
Tuberculin Test (Mantoux/PPD)	/ /
Blood Test (for anemia)	/ /
Urine Test	/ /
Blood Lead Test	/ /
Other	/ /

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER *(optional)* *and* RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

☐ Examination shows no condition of concern to school program activities.

☐ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

☐ Please check this box if you ***do not*** want the health examiner to fill out Part III.

➤ _____ _____
Signature of parent or guardian Date

Name, address, and telephone number of health examiner

➤ _____ _____
Signature of health examiner Date

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.