

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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Name:		
Relationship:		
Email:		
Phone:		
Alternate Phone:		
Address:		
City, State, Zip:		
Employer/Occupation:		
Lives with child?	<input type="checkbox"/> YES	<input type="checkbox"/> 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:			
<input type="checkbox"/> Wears glasses or contacts	<input type="checkbox"/> Has a hearing problem	<input type="checkbox"/> Born before 37 weeks	<input type="checkbox"/> Asthma
<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other (Please explain below)
<input type="checkbox"/> Child has a documented diagnosis/disability			
<input type="checkbox"/> Child has a physical condition which limits participation in classroom activities or physical education			
<input type="checkbox"/> Child has seen a professional to address mental/emotional/behavioral concerns in the past 12 months			
<input type="checkbox"/> Child has received an educational evaluation/assessment by an outside professional			
<input type="checkbox"/> Allergies: _____			
<input type="checkbox"/> Medications and Dosage: _____			
Please explain any of the above: _____			

<input type="checkbox"/> No known health problems			

Name:			
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<input type="checkbox"/> Medications and Dosage: _____			
Please explain any of the above: _____			

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<input type="checkbox"/> Child has received an educational evaluation/assessment by an outside professional			
<input type="checkbox"/> Allergies: _____			
<input type="checkbox"/> Medications and Dosage: _____			
Please explain any of the above: _____			

<input type="checkbox"/> 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:
<input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Hmong <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Tahitian <input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Hmong <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Tahitian <input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Hmong <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Tahitian <input type="checkbox"/> 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:
<input type="checkbox"/> No high school diploma <input type="checkbox"/> High school degree or equivalent (e.g., GED) <input type="checkbox"/> Some college but no degree <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor degree <input type="checkbox"/> Professional degree <input type="checkbox"/> Graduate degree <input type="checkbox"/> Doctorate degree	<input type="checkbox"/> No high school diploma <input type="checkbox"/> High school degree or equivalent (e.g., GED) <input type="checkbox"/> Some college but no degree <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor degree <input type="checkbox"/> Professional degree <input type="checkbox"/> Graduate degree <input type="checkbox"/> 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:	

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: _____

Address: _____

Telephone: _____

Date of Physical Exam: _____

Date This Form Completed: _____

Signature _____

Physician Physician's Assistant Nurse Practitioner

CHILD’S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD’S NAME	SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE 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* _____ MONTHS	BEGAN TALKING AT* _____ MONTHS	TOILET TRAINING STARTED AT* _____ MONTHS
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PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping Cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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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?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND:

PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, 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/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE
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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

Sacramento Regional Office

ADDRESS

2525 Natomas Park Drive, Suite 250

CITY

Sacramento

ZIP CODE

95833

AREA CODE/TELEPHONE NUMBER

916-263-5744

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)

Shalom School

(PRINT THE NAME OF THE CHILD)

(PRINT THE ADDRESS OF THE FACILITY)

2320 Sierra Blvd., Sacramento, CA 95825

(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