בס"ד

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

# GRADES 1-8 REGISTRATION FORM

**Candidate For Grade _____ 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

**Early Arrival Group** ☐ 7:30 am-8:30 am (Available Monday through Friday)
**Late Afternoon Group** ☐ 4:00 pm-6:00 pm (Available Monday through Thursday)

School Previously attended _____

School Recommended by _____

Important Notes:

_____

_____

_____

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 March 1 $250 ☐ After March 1 $350 ☐ After September 1 $450

I hereby register my child for the school term_____ 2024; to _____2025

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-_____**

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General Permission Form

Parents will be notified via letter and/or email about upcoming trips and any other off- campus activities. Please sign below to give your permission for all trips occurring this year.

I, the parent of (name all children in the school)

_____

_____

Family name:_____

in grade(s) _____,
hereby give my consent for the New England Hebrew Academy to take my child(ren) on any school trip or off-campus activities throughout the school year of 2024-2025.

I. I hereby agree to release, discharge and hold harmless the teachers, employees and directors of the New England Hebrew Academy from and against all actions, damages and liabilities arising out of or in any way related to such activities and trips.
II. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize N.E.H.A. to transport my child to the nearest Hospital and to secure for my child the necessary medical treatment.
III. The New England Hebrew Academy occasionally has the opportunity to highlight the accomplishments of our students or programs on our website. We may photograph or videotape your child during school events for this publicity. Public photos will not include any names and usually will not be an individual photo. The N.E.H.A. is hereby granted permission to publish these photos. If you do **not** wish to have your child photographed please email the office at office@TheNeha.com

**Parent Signature:**_____ **Date:**_____

# 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:**