



Student Information			
STUDENT'S LEGAL NAME: (Last, First, Middle)			PREVIOUS NAME:
BIRTHDATE: (mm/dd/yyyy)	GENDER: (Male/Female)	BIRTHPLACE: (City/State/Country)	GRADE LEVEL:
STUDENT E-MAIL:			
PRIMARY LANGUAGE SPOKEN BY STUDENT: (Please check one) <input type="checkbox"/> ENGLISH <input type="checkbox"/> RUSSIAN <input type="checkbox"/> SPANISH <input type="checkbox"/> UKRAINIAN <input type="checkbox"/> OTHER _____			
PRIMARY LANGUAGE SPOKEN AT HOME: (Please check one) <input type="checkbox"/> ENGLISH <input type="checkbox"/> RUSSIAN <input type="checkbox"/> SPANISH <input type="checkbox"/> UKRAINIAN <input type="checkbox"/> OTHER _____			
HAS YOUR STUDENT EVER QUALIFIED FOR OR BEEN ENROLLED IN A SPECIAL EDUCATION PROGRAM? IF YES, DOES YOUR STUDENT HAVE A CURRENT IEP PLAN? If yes, please submit a current IEP document for your student's school file.			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
HAS YOUR STUDENT EVER HAD A 504 PLAN?			<input type="checkbox"/> YES <input type="checkbox"/> NO
HAS YOUR STUDENT EVER PARTICIPATED IN: <input type="checkbox"/> TITLE <input type="checkbox"/> LAP <input type="checkbox"/> GIFTED <input type="checkbox"/> ESL/ELL <input type="checkbox"/> PRE-SCHOOL PROGRAM (From: mm/dd/yy _____ To: mm/dd/yy _____) <input type="checkbox"/> OTHER _____			

Previous School Information			
SCHOOL NAME:	DISTRICT:	FROM: (Month/Year)	TO: (Month/Year)
SCHOOL ADDRESS:		CITY/STATE/ZIP	
HAS YOUR STUDENT EVER ATTENDED EVERGREEN PUBLIC SCHOOLS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE NAME THE SCHOOL(S) ATTENDED:		
IS THE STUDENT CURRENTLY SUSPENDED OR EXPELLED FROM ANY SCHOOL OR EDUCATION SYSTEM?	<input type="checkbox"/> YES <input type="checkbox"/> NO		

Ethnicity and Race			
PLEASE ANSWER BOTH QUESTIONS 1 AND 2 BOTH RESPONSES NEEDED PER WASHINGTON OSPI AND FEDERAL REQUIREMENTS			
QUESTION 1: Is your child of Hispanic or Latino origin? (Please check all that apply)	<input type="checkbox"/> NOT HISPANIC/LATINO <input type="checkbox"/> CENTRAL AMERICAN <input type="checkbox"/> CUBAN	<input type="checkbox"/> DOMINICAN <input type="checkbox"/> LATIN AMERICAN <input type="checkbox"/> MEXICAN/CHICANO <input type="checkbox"/> MEXICAN AMERICAN	<input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> SOUTH AMERICAN <input type="checkbox"/> SPANIARD <input type="checkbox"/> OTHER HISPANIC / LATINO
QUESTION 2: What race do you consider your child? (Please check all that apply)	<input type="checkbox"/> AFRICAN AMERICAN OR BLACK <input type="checkbox"/> WHITE OR CAUCASIAN <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> CAMBODIAN <input type="checkbox"/> CHINESE <input type="checkbox"/> FILIPINO <input type="checkbox"/> HMONG <input type="checkbox"/> INDONESIAN <input type="checkbox"/> JAPANESE <input type="checkbox"/> KOREAN <input type="checkbox"/> LAOTIAN <input type="checkbox"/> MALAYSIAN <input type="checkbox"/> PAKISTANI <input type="checkbox"/> SINGAPOREAN <input type="checkbox"/> TAIWANESE <input type="checkbox"/> THAI <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER ASIAN AMERICAN	<input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> FIJIAN <input type="checkbox"/> GUAMANIAN or CHAMORRO <input type="checkbox"/> MARIANA ISLANDER <input type="checkbox"/> MELANESIAN <input type="checkbox"/> MICRONESIAN <input type="checkbox"/> SAMOAN <input type="checkbox"/> TONGAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> ALASKA NATIVE <input type="checkbox"/> CHEHALIS <input type="checkbox"/> COLVILLE <input type="checkbox"/> COWLITZ <input type="checkbox"/> HOH <input type="checkbox"/> JAMESTOWN <input type="checkbox"/> KALISPEL <input type="checkbox"/> LOWER ELWHA <input type="checkbox"/> LUMMI <input type="checkbox"/> MAKAH <input type="checkbox"/> MUCKLESHOOT	<input type="checkbox"/> NISQUALLY <input type="checkbox"/> NOOKSACK <input type="checkbox"/> PORT GAMBLE CLALLAM <input type="checkbox"/> PUYALLUP <input type="checkbox"/> QUILEUTE <input type="checkbox"/> QUINAULT <input type="checkbox"/> SAMISH <input type="checkbox"/> SAUK-SUIATTLE <input type="checkbox"/> SHOALWATER <input type="checkbox"/> SKOKOMISH <input type="checkbox"/> SNOQUALMIE <input type="checkbox"/> SPOKANE <input type="checkbox"/> SQUAXIN ISLAND <input type="checkbox"/> STILLAGUAMISH <input type="checkbox"/> SUQUAMISH <input type="checkbox"/> SWINOMISH <input type="checkbox"/> TULALIP <input type="checkbox"/> YAKIMA <input type="checkbox"/> OTHER WASHINGTON INDIAN <input type="checkbox"/> OTHER AMERICAN INDIAN
OFFICE USE ONLY:			
Q1-DATA:	<input type="checkbox"/> STAFF <input type="checkbox"/> PARENT		
Q2-DATA:	<input type="checkbox"/> STAFF <input type="checkbox"/> PARENT		

OFFICE USE ONLY: (Do Not Write Below)				
STUDENT ID (Other ID)	DEFAULT ENTITY SCHOOL	SCHOOL ENTRY DATE / /	FUTURE SCHOOL	FOOD SERVICE KEYPAD #
TEACHER	HOMEROOM #	GRADE LEVEL	<input type="checkbox"/> NO PHOTO (Form DIS354 MUST be on file)	<input type="checkbox"/> NO INTERNET ACCESS (Form DIS353 MUST be on file)
SESSION <input type="checkbox"/> AM <input type="checkbox"/> PM	WALKER? <input type="checkbox"/> YES <input type="checkbox"/> NO	SPECIFIC TRANSPORTATION INFORMATION	NOTES:	
BUS IN	BUS OUT			



STUDENT REGISTRATION FORM / #2 of 4

Print with a ball point pen in BLUE or BLACK ink only.

Family 1 Parent/Guardian (with whom the student lives)			
PARENT/GUARDIAN 1 NAME: (Last, First, Middle Initial)		RELATIONSHIP TO STUDENT:	
E-MAIL:			
ADDRESS: (Where Student Lives) City/State/Zip		PRIMARY PHONE: USED FOR DISTRICT NOTIFICATIONS ()	TYPE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> _____
MAILING ADDRESS: (If different from above) City/State/Zip		SECONDARY PHONE: ()	TYPE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> _____
PARENT/GUARDIAN 2 NAME (SAME HOUSEHOLD): (Last, First, Middle Initial)		RELATIONSHIP TO STUDENT:	
E-MAIL:		SECONDARY PHONE: ()	TYPE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> _____
Does the student have an additional family parent/guardian? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide additional information below.			

Family 2 Parent/Guardian			
PARENT/GUARDIAN NAME: (Last, First, Middle Initial)		RELATIONSHIP TO STUDENT:	
E-MAIL:		<input type="checkbox"/> SHARED/PARTIAL CUSTODY <input type="checkbox"/> NON-RESIDENTIAL / NON-CUSTODIAL	
MAILING ADDRESS: City/State/Zip		PRIMARY PHONE: ()	TYPE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> _____
SHOULD THIS HOUSEHOLD RECEIVE DISTRICT MAILINGS? <input type="checkbox"/> YES <input type="checkbox"/> NO		SECONDARY PHONE: ()	TYPE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> _____
PARENT/GUARDIAN NAME: (Last, First, Middle Initial)		RELATIONSHIP TO STUDENT:	
E-MAIL:		SECONDARY PHONE: ()	TYPE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> _____

Legal Restrictions	
ARE THERE ANY CURRENT WASHINGTON STATE RESTRAINING COURT ORDERS OR LEGAL RESTRICTIONS IN EFFECT PREVENTING A NON-CUSTODIAL PERSON FROM VISITING THE SCHOOL, HAVING ACCESS TO SCHOOL REPORTS/RECORDS, OR REMOVING YOUR STUDENT FROM SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes," legal papers must be on file with the school.	
IF YES, WHOM IS THE RESTRAINING ORDER OR LEGAL RESTRICTION AGAINST?	NAME(S) AND RELATIONSHIP TO STUDENT:

Family Information: List ALL siblings living in the home AND attending Evergreen Public Schools						
LAST NAME	FIRST NAME	MIDDLE INITIAL	GENDER (Male/Female)	BIRTHDATE (mm/dd/yyyy)	AGE	SCHOOL ATTENDING



STUDENT REGISTRATION FORM / #3 of 4

Print with a ball point pen in BLUE or BLACK ink only.

Family Information: List ALL siblings living in the home ages 0 through pre-kindergarten

LAST NAME	FIRST NAME	MIDDLE INITIAL	GENDER (Male/Female)	BIRTHDATE (mm/dd/yyyy)	AGE	PRE-SCHOOL PROGRAM (If Applicable)

Child Care/Day Care, if applicable (If this does not apply to your student, you do not need to complete this section of the application.)

DOES YOUR STUDENT ATTEND CHILD CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHEN DOES YOUR STUDENT ATTEND? (Before School? After School?)
CHILD CARE PROVIDER:		PHONE NUMBER: (Include Area Code)
ADDRESS: City/State/Zip		

Emergency Contacts: (LOCAL AREA ONLY, PLEASE.)

When injury, illness, or other non-emergency situations occur involving your child, we want to be able to quickly reach families or other responsible adults. In the event we can not reach a parent/guardian, please list persons you trust who are available during the day to provide care for your child.

#1 EMERGENCY CONTACT: (Other than parent/guardian) Last, First, Middle Initial		RELATIONSHIP TO STUDENT:
PRIMARY PHONE NUMBER: (Include Area Code)	SECONDARY PHONE NUMBER: (Include Area Code)	OTHER PHONE NUMBER: (Include Area Code)
ADDRESS: City/State/Zip		
#2 EMERGENCY CONTACT: (Other than parent/guardian) Last, First, Middle Initial		RELATIONSHIP TO STUDENT:
PRIMARY PHONE NUMBER: (Include Area Code)	SECONDARY PHONE NUMBER: (Include Area Code)	OTHER PHONE NUMBER: (Include Area Code)
ADDRESS: City/State/Zip		
#3 EMERGENCY CONTACT: (Other than parent/guardian) Last, First, Middle Initial		RELATIONSHIP TO STUDENT:
PRIMARY PHONE NUMBER: (Include Area Code)	SECONDARY PHONE NUMBER: (Include Area Code)	OTHER PHONE NUMBER: (Include Area Code)
ADDRESS: City/State/Zip		

STUDENT RELEASE AUTHORIZATION: In the event that school is unable to contact the parent/guardian, I authorize that my child may be released to the Emergency Contact(s), Child Care/Day Care provider listed above.

LEGAL PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

EMERGENCY MEDICAL AUTHORIZATION: I understand that in the event of accident or illness, every effort will be made to contact parent/guardian immediately. If parent/guardian cannot be reached, I authorize school authorities to obtain emergency care for my child.

LEGAL PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

VERIFICATION OF INFORMATION: The information on this form is true and accurate as of this date. I understand that falsification of information to achieve enrollment or assignment may cause for revocation of the student's enrollment or assignment to a school in Evergreen Public Schools.

LEGAL PARENT/GUARDIAN SIGNATURE: _____ DATE: _____



Student Residency

The following questions can help determine the services your student may be eligible to receive under the Title I Part A and/or Federal McKinney-Vento Act 42 U.S.C. 11435. Eligibility can be determined by completing this confidential questionnaire. The purpose of this information is to ensure the rights of your student/s under the McKinney-Vento Act. **This information is confidential!**

STUDENT'S LEGAL NAME: (Last, First, Middle)		BIRTH DATE
SCHOOL		GRADE LEVEL
1. Is this student's home address a temporary living arrangement?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Is this a temporary living arrangement due to a loss of housing or economic hardship?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Is this student in a temporary foster care placement or awaiting foster care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. As a student, are you living with someone other than your parent or legal guardian?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Unknown nighttime residence?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Is the student an unaccompanied youth?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If you answered NO to all of the above questions, you may stop this section here		

If you answered YES to any of the above questions, please complete the remainder of this section.

7. Where is this student currently living?		<input type="checkbox"/> In a motel	<input type="checkbox"/> With more than one family in a house or apartment
		<input type="checkbox"/> In a shelter	<input type="checkbox"/> In a location not designed for sleeping accommodations such as a car, park, or campsite
		<input type="checkbox"/> Moving from place to place	<input type="checkbox"/> Other: _____
		<input type="checkbox"/> Group home	
Please complete 8A, 8B, or 8C:	8A. ADDRESS OF CURRENT RESIDENCE		
	8B. NAME OF MOTEL/SHELTER OF CURRENT RESIDENCE		
	8C. NAME OF "GENERAL AREA" OF CURRENT RESIDENCE		
9. PHONE NUMBER OR CONTACT NUMBER:			
10. NAME OF CONTACT:			
PRINT NAME OF PARENT(S)/LEGAL GUARDIAN(S): (Or unaccompanied youth)			
SIGNATURE OF PARENT/LEGAL GUARDIAN: (Or unaccompanied youth)			
DATE:			

FOR SCHOOL STAFF ONLY:

If 'Yes' is marked in the Student Residency block for any question 1-6, please send a copy of this page to Legacy High School, ATTN: Students in Transition Coordinator or fax to 360-604-3902

Evergreen School District #114 Immunization Requirements

TO: Parents of _____ Evergreen School District #114 _____ Students

FROM: Health Services Department

THE ATTACHED CERTIFICATE OF IMMUNIZATION STATUS MUST BE SUBMITTED ON OR BEFORE THE FIRST DAY OF SCHOOL IN ORDER FOR YOUR CHILD TO ATTEND SCHOOL.

Washington State Law requires certification of immunization for all school children. Schools must exclude children from attending who do not provide proof of, or exemption from, meeting immunization requirements (RCW 28A.210 & WAC 180-38 & 246-100-166).

COMPLETE THE CERTIFICATE OF IMMUNIZATION STATUS BY:

- Entering the month, day and year, when each required dose of a vaccine was given. (If you do not know the specific day, the health services professional will assume the first of the month.)

OR

- Completing one of the statements of exemption. (Please note that your child will be excluded from school for the duration of an outbreak of a vaccine-preventable disease for which your child is exempted.)

OR

- Notifying the school that a schedule of immunization has been started and will be completed in accordance with your doctor's recommended schedule. Immunizations are available from your private physician, or you may obtain them from:

Weekdays:

see attached

Telephone:

- Bring records of your child's immunization to _____ see attached _____ to assure that your child receives the correct vaccine.

SIGN THE CERTIFICATE INDICATING YOUR INFORMATION IS CORRECT.

Please contact your child's school if you need further assistance in completing the certificate.



Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Office Use Only:	
Reviewed by: _____	Date: _____
Signed Cert. of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

Child's Last Name: _____	First Name: _____	Middle Initial: _____	Birthdate (mm/dd/yyyy): _____	Sex: _____	I certify that the information provided on this form is correct and verifiable.
Symbols below: ◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only				Parent/Guardian Name (please print): _____	

Vaccine	Dose	Date		
		Month	Day	Year
◆ Hepatitis B (Hep B)				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)				
	1			
	2			
● Haemophilus influenzae type b (Hib)				
	1			
	2			
	3			
	4			
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date		
		Month	Day	Year
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox) or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			
Office Use Only: Immunization information updated and verified with parent/guardian permission:				
Printed Staff Name	Date	Printed Staff Name	Date	
Printed Staff Name	Date	Printed Staff Name	Date	

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

1) Chickenpox disease verified by printout from CHILD Profile Immunization Registry
Must be marked by printout (not by hand) to be valid.

2) Chickenpox disease verified by Health Care Provider (HCP)
If you choose this box, mark 2A OR 2B below.
 2A) Signed note from HCP attached OR
 2B) HCP signed here and print name below:

 Licensed health care provider (HCP) Signature _____ Date _____
 (MD, DO, ND, PA, ARNP)
 HCP Printed Name: _____

3) Chickenpox disease verified by school staff from CHILD Profile Immunization Registry
If you choose this box, staff must initial that parent or guardian approves: _____ (initial) _____ (date)

4) Chickenpox disease verified by parent*
If you choose this box, fill in the date or child's age when he or she had the disease:
 Age/Date of disease: _____
 *Can ONLY verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.
Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. **Signed lab report(s) MUST also be attached.**

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	

Licensed health care provider (HCP) Signature _____ Date _____
 (MD, DO, ND, PA, ARNP)
 HCP Printed Name: _____

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

Vaccine	Dose	Date		
		Month	Day	Year
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
DTaP	1	01	12	2011
DTaP	2	03	20	2011
DTaP	3	06	01	2011

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

- 1) If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
- 2) If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
- 3) If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
- 4) If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: <http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm>

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Vaccine Trade Names in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)									
Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menaetra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqa	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrel)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)							
Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	<i>Haemophilus influenzae</i> type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

2010-01-13 05:10

Certificate of Exemption

For School, Child Care and Preschool Immunization Requirements¹



DIRECTIONS: All exemptions must have a licensed health care provider sign & date Box 1 ('Provider Statement').² Exception: Box 1 is not required for religious exemptions when Box 2 ('Demonstration of Religious Membership') is completed. All exemptions must also have a parent/guardian sign & date Box 3 ('Parent/Guardian Statement').

Child's Last Name:	First Name:	Middle Initial:	Birthdate (mm/dd/yyyy):	Sex:	Parent/Guardian Name (please print):
---------------------------	--------------------	------------------------	--------------------------------	-------------	---

Parent/Guardian, please choose the exemption(s) that apply to your child below.

<input type="checkbox"/> Temporary Medical Exemption <input type="checkbox"/> Permanent Medical Exemption <hr/> Vaccine(s) _____ Until _____ Date (or Permanent) <hr/> Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP) <hr/> X _____ X _____ Signature of Licensed Health Care Provider Date	<input type="checkbox"/> Personal/Philosophical Exemption (see Box 1) <input type="checkbox"/> Religious Exemption (see Box 1) <input type="checkbox"/> Religious Membership Exemption (see Box 2) I do not want my child to get the following vaccine(s): <input type="checkbox"/> Diphtheria <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hib <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Pertussis (whooping cough) <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Polio <input type="checkbox"/> Rubella <input type="checkbox"/> Tetanus <input type="checkbox"/> Varicella (chickenpox) <input type="checkbox"/> Other (indicate): _____
--	---

Box 1
<p>Provider Statement²: "I, _____, am a qualified provider (MD, DO, ND, PA, ARNP) licensed under Title 18 RCW. I confirm that the parent or guardian signing in Box 3 (Parent/Guardian Statement) has received information on the benefits and risks of immunization to their child as a condition for exempting their child for medical, religious, personal, or philosophical reasons." X _____ Signature of Licensed Health Care Provider (MD, DO, ND, PA, ARNP) X _____ Date</p>

Box 2
<p>Parent/Guardian Demonstration of Religious Membership: "I am a member of a church or religious body whose beliefs or teachings do not allow for medical treatment from a health care practitioner. By supplying the information requested below, no further proof or signed provider statement in Box 1 is required for this religious exemption." X _____ Name of Church or Religious Body X _____ X _____ Signature of Parent or Guardian Date</p>

Box 3
<p>Parent/Guardian Statement: "I certify that all the information provided on this certificate is correct and verifiable. I understand that if there is an outbreak of a vaccine-preventable disease my child has not been fully immunized against (as indicated above, for medical, personal/philosophical or religious reasons), my child may be at risk for disease and can be excluded from school, child care, or preschool until the outbreak is over." X _____ X _____ Signature of Parent or Guardian Date</p>

If you have a disability and need this document in a different format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

¹ RCW 28A.210.080-090 states that before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the State Board of Health, or (3) a certificate of exemption, signed by a parent or guardian and a licensed health care provider.

² A letter may substitute for a signed 'Provider Statement' on this certificate. To be accepted, the letter must reference the child's name on this certificate, confirm that the child's parent or guardian got information on the risks and benefits of immunization to their child, and be signed by a licensed health care provider.

EVERGREEN PUBLIC SCHOOLS

Family Emergency Plan

Elementary School

In the event of an early or emergency school closure, your child and the school need to know where he/she should go. Please discuss this information with your child, and then fill out this form for **each** child you have at this school. Please return the white and yellow copies to school, and retain the pink copy for your records. Please keep in mind that the telephone **will not be available** to your child.

Student Name: _____		Date: _____		
Teacher: _____		Grade: _____		
Brothers and Sisters at this school (beginning with the oldest):				
Name: _____		Grade: _____	Teacher: _____	
Name: _____		Grade: _____	Teacher: _____	
Name: _____		Grade: _____	Teacher: _____	
Contacts:	Home #	Work Phone #	Cell Phone #	Pager #
Mother: _____	_____	_____	_____	_____
Father: _____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

PLEASE CHECK ONE OPTION	
I will pick up my child:	
My child is to go home as usual by: <input type="checkbox"/> Bus # _____ <input type="checkbox"/> Walk Home	
My child is to go to the normal day care provider:	
My child is to go to the home of: Name: _____	
Address: _____ Phone #: _____	
They will get there by: <input type="checkbox"/> Bus # _____ <input type="checkbox"/> Walking Home	
My child will be picked up by one of the following people: (Identification will be required.)	
Name: _____ Phone #: _____	
Name: _____ Phone #: _____	
Parent/Guardian Signature: _____ Date: _____	
Your signature authorizes the school to release your child to the party listed above.	

EMERGENCY INFORMATION HOTLINE 604-3637

Radio and TV stations will be your primary information sources for emergency school closure.

Flash Alert: Sign up to receive e-mail and phone text notification of school closures, snow closures, and schedule changes on the Evergreen Public Schools website at **www.egreen.wednet.edu**.

White – Teacher Copy Canary – Office Copy Pink – Parent Copy

EVERGREEN SCHOOL DISTRICT NO. 114

Health and Emergency Form

Please print in blue or black ink.

School: _____ Grade: _____ Previous School: _____

Student Name: _____ Gender: _____ Birthdate: _____

Student Address: _____
ADDRESS CITY/STATE/ZIP

Father: _____
NAME HOME PHONE WORK PHONE CELL PHONE

Mother: _____
NAME HOME PHONE WORK PHONE CELL PHONE

MY CHILD HAS HEALTH PROBLEM(S): *If yes, please list problems below. YES NO

HEALTH PROBLEM(S):

Please list and describe each of your student's health problem(s) below. (Such as asthma, diabetes, seizures, bee sting, etc.)

Special instructions related to health problem(s) listed above: _____

MEDICATIONS TAKEN:

If medications are to be taken during school hours, the original container must be maintained within the school office with the health care provider's directions and the Authorization for Administration of Medication at School form signed by the health care provider and parent/guardian allowing school personnel to administer the medication.

Medication _____ Prescribed by _____

Medication _____ Prescribed by _____

SCHOOL/PHYSICAL ACTIVITIES:

Please list all school/physical activities in which student should not participate. Parent or guardian must provide documentation as to reasons for non-participation.

EMERGENCY AUTHORIZATION/INFORMATION RELEASE:

Various state and federal laws prohibit the release of medical information. We are requesting authorization to release on a "need to know" basis health information which will help staff attend to your child's health needs. Examples of such situations would be to share health information with teachers and bus drivers, when students have health conditions such as asthma, diabetes, seizures, bee sting, etc. which may require special attention and/or emergency preparedness. Sharing of this health information will allow staff to be better prepared if a medical emergency arises.

School personnel may share information as needed to protect the health and safety of my child.

In an emergency, I authorize school personnel to call Dr. _____ Phone: _____

or Dr. _____ Phone: _____ Preferred Hospital: _____

PARENT/GUARDIAN SIGNATURE: _____ Date: _____



REQUEST FOR RELEASE OF STUDENT ACADEMIC AND IMMUNIZATION INFORMATION - ELEMENTARY SCHOOLS

PREVIOUS SCHOOL INFORMATION:

DATE _____

SCHOOL _____

ADDRESS _____

PHONE _____ FAX _____

STUDENT NAME _____ BIRTHDATE _____ GR _____

The above student has registered at:

- Burnt Bridge Creek**
14619-A NE 49th St.
Vancouver, WA 98682
(360) 604-6750
FAX (360) 604-6751
- Endeavour**
2701 NE Four Seasons Ln
Vancouver, WA 98684
(360) 604-4920
FAX (360) 604-4922
- Illalhee**
19401 SE 1st St.
Camas, WA 98607
(360) 604-3350
FAX (360) 604-3352
- Riverview**
12601 SE Riveridge Dr.
Vancouver, WA 98683
(360) 604-6625
FAX (360) 604-6627
- Burton**
14015 NE 28th St.
Vancouver, WA 98682
(360) 604-4975
FAX (360) 604-4977
- Fircrest**
12001 NE 9th St.
Vancouver, WA 98684
(360) 604-6925
FAX (360) 604-6927
- Image**
4400 NE 122nd Ave.
Vancouver, WA 98682
(360) 604-6850
FAX (360) 604-6852
- Sifton**
7301 NE 137th Ave.
Vancouver, WA 98682
(360) 604-6675
FAX (360) 604-6677
- Columbia Valley**
17500 SE Sequoia Cir.
Vancouver, WA 98683
(360) 604-3375
FAX (360) 604-3377
- Fisher's Landing**
3800 SE Hiddenbrook Dr.
Vancouver, WA 98683
(360) 604-6650
FAX (360) 604-6652
- Marrion**
10119 NE 14th St.
Vancouver, WA 98664
(360) 604-6825
FAX (360) 604-6827
- Silver Star**
10500 NE 86th St.
Vancouver, WA 98662
(360) 604-6775
FAX (360) 604-6777
- Crestline**
13003 SE 7th St.
Vancouver, WA 98683
(360) 604-3325
FAX (360) 604-3327
- Harmony**
17404-A NE 18th St.
Vancouver, WA 98684
(360) 604-6600
FAX (360) 604-6602
- Mill Plain**
400 SE 164th Ave.
Vancouver, 98684
(360) 604-6800
FAX (360) 604-6802
- Sunset**
9001 NE 95th St.
Vancouver, WA 98662
(360) 604-6900
FAX (360) 604-6902
- Early Childhood Center**
14405 NE 28th St.
Vancouver, WA 98682
(360) 604-3925
FAX (360) 604-3927
- Hearthwood**
801 NE Hearthwood Blvd.
Vancouver, WA 98684
(360) 604-6875
FAX (360) 604-6877
- Orchards**
11405 NE 69th St.
Vancouver, WA 98662
(360) 604-6975
FAX (360) 604-6977
- York**
9301 NE 152nd Ave.
Vancouver, WA 98682
(360) 604-3975
FAX (360) 604-3977
- Ellsworth**
512 SE Ellsworth Rd.
Vancouver, WA 98644
(360) 604-6950
FAX (360) 604-6952
- Home Choice Academy**
PO Box 8910
Vancouver, WA 98668
(360) 604-4032
FAX (360) 604-4116
- Pioneer**
7212 NE 166th Ave.
Vancouver, WA 98682
(360) 604-3300
FAX (360) 604-3302

Please sent all pertinent information from this student's records that will assist us in planning and carrying out his/her educational program. Please include:

- Immunizations
- Discipline
- Fines
- ELL
- Report Cards
- State Assessment Scores
- Highly Capable/Gifted
- 504 Plan
- Title 1

_____ Special Education

As provided under the Family Rights and Privacy Act of 1974, I understand that I may obtain a copy of my child's personally identifiable records. I am aware that I may challenge the content of these records. Finally, no one will send these records to a non-public school agency without my written consent.

Parent/Guardian Signature _____ Date _____

WHITE – Receiving School

YELLOW – Sending School District



REQUEST FOR RELEASE OF STUDENT ACADEMIC AND IMMUNIZATION INFORMATION - MIDDLE SCHOOLS

PREVIOUS SCHOOL INFORMATION: DATE _____

SCHOOL _____

ADDRESS _____

PHONE _____ FAX _____

STUDENT NAME _____ BIRTHDATE _____ GR _____
(Please Print)

The above student has registered at:

- Cascade, Covington, Frontier, Home Choice, iQ Academy, Pacific, Shahala, Wy'east
13900 NE 18th St. Vancouver, WA 98684 (360) 604-3600 FAX (360) 604-3614
11200 NE Rosewood Rd. Vancouver, WA 98662 (360) 604-6300 FAX (360) 604-6302
7600 NE 166th Ave. Vancouver, WA 98682 (360) 604-3200 FAX (360) 604-3202
PO Box 8910 Vancouver, WA 98668 (360) 604-4032 FAX (360) 604-4116
PO Box 8910 Vancouver, WA 98668 (360) 604-4057 FAX (360) 604-4115
2017 NE 172nd Ave. Vancouver, WA 98684 (360) 604-6500 FAX (360) 604-6502
601 SE 192nd Ave. Vancouver, WA 98683 (360) 604-3800 FAX (360) 604-3822
1112 SE 136th Ave. Vancouver, WA 98683 (360) 604-6400 FAX (360) 604-6402

Please sent all pertinent information from this student's records that will assist us in planning and carrying out his/her educational program. Please include:

- Immunizations, Discipline, Fines, ELL, Report Cards/Transcripts
State Assessment Scores, Highly Capable/Gifted, 504 Plan, Title 1

Special Education

Comments: _____

As provided under the Family Rights and Privacy Act of 1974, I understand that I may obtain a copy of my child's personally identifiable records. I am aware that I may challenge the content of these records. Finally, no one will send these records to a non-public school agency without my written consent.

Parent/Guardian Signature _____ Date _____

**CLARK COUNTY SCHOOL DISTRICTS
CLARK COUNTY, WASHINGTON**

Call Made _____
Date

Homeroom Advisor/Teacher:

Form Sent _____
Date

Records Sent _____
Date

REQUEST FOR SENDING PERSONALLY IDENTIFIABLE RECORDS

Student _____ **Date** _____

Birthdate _____

I request an exchange of records:

_____ **Permanent Records**

_____ **Health Records**

_____ **Special Education Records (including speech and language records)**

_____ **Other** _____

This information is to be exchanged between the
'new' school name/address below:

'old' school name/address below:

and

for the following reason: _____

As provided under the Family Rights and Privacy Act of 1974, I understand that I may obtain a copy of my child's personally identifiable records. I am aware that I may challenge the content of these records. I also understand that the school will treat these records confidentially. Finally, no one will send these records to a non-public school agency without my written consent.

Signature

Relationship

Address

Phone



Home Language Survey
 Washington State
 Transitional Bilingual Instructional Program

Student's Name		Date
School		Grade
SSID		Gender
1. ____ Yes ____ No If yes, list language(s)	Is a language other than English spoken in the home? Language(s) most often used by : Father _____ Mother _____ Guardian _____	
2. ____ Yes ____ No If yes, list language(s)	Is your child's first language a language other than English? _____	
_____ () _____ Parent or Guardian's Name Phone Number		
_____ City Zip		
Student's Country of Origin _____		
Parent or Guardian's Signature _____ Date _____		
Reference to WAC392-160-005. <ul style="list-style-type: none"> • "Primary language" means the language most often used by a student (not necessarily by parents, guardians, or others) for communication in the student's place of residence. • "Eligible student" means any student who meets the following two conditions: <ul style="list-style-type: none"> (a) The primary language of the student must be other than English; and (b) The student's English skills must be sufficiently deficient or absent to impair learning. 		

IF THE ANSWER TO QUESTION **NUMBER TWO** ABOVE WAS **"YES"**: REFER THE STUDENT FOR TESTING ON THE WASHINGTON LANGUAGE PROFICIENCY PLACEMENT TEST.

=====

<p>Please Complete the Following:</p> <p>A. _____ For how many months has the student attended school in the United States (grades K – 12) before enrolling in this district?</p> <p>B. _____ For how many months has the student received formal education outside the United States in his/her native language (equivalent to grades K – 12) before enrolling in this district?</p> <p>_____</p> <p>Guidance:</p> <ul style="list-style-type: none"> • One (1) school year = ten (10) months. • "Formal education" does not include refugee camp schools or other unaccredited programs for children. • "Native Language" refers to the family's dominant language.
--