NEW STUDENT REGISTRATION CHECKLIST
Quincy High School

The following items must be presented for new student registration at Quincy High School:

When the new student comes to Quincy High School, the student should be accompanied by a parent or guardian and should bring all of the below records from their previous school. The student should also bring all of the attached documents completely filled out.

The following items must be presented for new student registration at Quincy High School:

When the new student comes

RECORDS:

1. Immunization (shots) records
2. Transcript showing past school classes and grades
3. If student is transferring in the middle of the school year and is coming from another school, the student should bring a list of classes and withdrawal grades from the student’s former school.
4. Address and phone number of former school
5. Current address and emergency information
6. Birth Certificate

COUNSELING:

Students will be assigned to a counselor. The counselor will review the student’s records and make a schedule of classes at Quincy High School for the student.

1. QHS staff will enroll student with their class (Fr., Soph., etc.).
2. The counselor will give the student a student handbook and take the student to the front office for locker assignment, ASB, and lunch ticket purchase.

The student is expected to start classes beginning with first period at 8:10 am.
CONSENT FOR MUTUAL RELEASE AND/OR EXCHANGE OF INFORMATION

Please send Records to: Quincy High School
Attention: Kelli McKay
16 Sixth Ave SW, Quincy, WA 98848
TEL: (509) 787-3501    FAX: (509) 787-8988

Registrar

(Previous School)                    (TO THE ATTENTION OF:)

(Street Address, City, State & Zip Code)

(Telephone)         (Fax)

I hereby authorize the release and/or exchange of information between the above school/agency and Quincy School District regarding:

Student Name: ___________________________________________ Birth Date: ______________

Please fax & mail all pertinent information/records for this student, including:

☐ Transcript
☐ Withdrawal Grades (including percentages)
☐ Attendance History
☐ Discipline History
☐ Immunization Records
☐ Birth Certificate
☐ Other: __________________________________________________

I understand that the information obtained will be treated in a confidential manner and will not be transmitted to a third party without my permission. I also understand that it is my right to request a copy of all information and contest any information I feel is incorrect. This authorization expires one year from the date of signature unless otherwise specified.

Date

Parent/Guardian Signature     Telephone Number

Street Address       City, State, Zip Code

Purpose: As a parent or guardian you have the right to give permission or not give permission for the release of your child’s records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the federal Education Rights and Privacy Act (for example, transfer of records from one school district to another). It also provides you the opportunity to talk with the school district and ask for an explanation as to why the information is being requested and by whom.

Propósito: Como un padre o guardián usted tiene el derecho de dar permiso o de no dar permiso para que se compartan los archivos de su niño/a con otras personas o agencies. Esta petición le provee la oportunidad de aprobar o de no aprobar tal petición solamente que el compartir de archivos sea permitido bajo una de las excepciones bajo las reglas implementando el Acto de Derechos y Privacidad de Educación Federal (por ejemplo. Trasferencia de archivos de un distrito escolar a otro). También le provee la oportunidad de hablar con el distrito escolar y pedir una explicación de porque se esta pediendo esta información y por quien.
LISTA DE REVISIÒN PARA ALUMNOS REGISTRANDÓSE
En la Escuela Secundaria de Quincy

La siguientes cosas necesitan ser presentadas para registrarse en la Escuela Secundaria de Quincy:

Cuando el/la alumno/a viene a la Escuela Secundaria de Quincy, el/la alumno/a debe ser acompañado por sus padres o su guardiano, y traer todos los archivos de la escuela anterior. El estudiante también debería traer todos los documentos adjuntos y completamente llenados.

ARCHIVOS:

1. Archivo de Vacunas
2. Archivos demostrando las calificaciones y clases tomadas anteriormente
3. Si el/la alumno/a se está cambiando en el medio de el año escolar debe traer la lista de clases y su archivo de retiro de la escuela anterior.
4. El domicilio y el número de teléfono de la escuela anterior
5. El domicilio y información más reciente del alumno/a
6. Acta de nacimiento

CONSEJERÍA:

El/la alumno/a va ser presentado con un consejero. El consejero va a revisar los archivos del alumno y va hacerle un horario de las clases que el alumno/a va tomar en la Escuela Secundaria de Quincy.

1. Los consejeros de la Escuela Secundaria de Quincy enlistaran al alumno/a con otros alumnos de su grado.
2. Los consejeros le darán a el/la alumno/a un libro de las reglas, y lo llevarán a la oficina general para darle el cajón (para guardar sus pertenencias) y para que compre su tickete de comida.

El/la alumno/a debe estar listo para entrar a la escuela y empezar sus primeras clases a las 8:10 a.m.
Parents - Are Your Kids Ready for School?
Required Immunizations for School Year 2014-2015

<table>
<thead>
<tr>
<th>Grade</th>
<th>Hepatitis B</th>
<th>DTaP/Td/Tdap* (Diphtheria, Tetanus, Pertussis)</th>
<th>Polio*</th>
<th>MMR (Measles, Mumps, Rubella)</th>
<th>Varicella (Chickenpox)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kindergarten – 5th Grade</td>
<td>3 doses</td>
<td>5 doses</td>
<td>4 doses</td>
<td>2 doses</td>
<td>2 doses OR Healthcare provider verifies child had disease</td>
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<tr>
<td>6th Grade</td>
<td>3 doses</td>
<td>5 doses DTaP AND 1 dose Tdap</td>
<td>4 doses</td>
<td>2 doses</td>
<td>2 doses OR Healthcare provider verifies child had disease</td>
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<tr>
<td>7th – 12th Grade</td>
<td>3 doses</td>
<td>5 doses DTaP AND 1 dose Tdap</td>
<td>4 doses</td>
<td>2 doses</td>
<td>Recommended, but not required.</td>
</tr>
</tbody>
</table>

*Vaccine doses required may be fewer than listed.

- Students must meet minimum intervals and ages to be in compliance with the requirements. Talk to your healthcare provider or school staff if you have questions about school immunization requirements.
- Find information on other recommended vaccines not required for school: [www.immunize.org/cdc/schedules/](http://www.immunize.org/cdc/schedules/)

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711). DOH 348-295 December 2013
<table>
<thead>
<tr>
<th>Student Information</th>
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<tbody>
<tr>
<td><strong>Student Legal</strong></td>
<td><strong>Primary Phone</strong></td>
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<td><strong>Last Name</strong></td>
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<td><strong>First Name</strong></td>
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<tr>
<td><strong>Birth Date</strong></td>
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<tr>
<td><strong>Legal Parent/Guardian #1</strong></td>
<td><strong>Legal Parent/Guardian #2</strong></td>
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<tr>
<td><strong>Last Name</strong></td>
<td><strong>Street/Apt #, PO BOX/City/State/Zip</strong></td>
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<tr>
<td><strong>First Name</strong></td>
<td><strong>Mailing Address:</strong></td>
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<td><strong>Primary Phone</strong></td>
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<td><strong>Both Parents</strong></td>
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<td><strong>Parent/Guardian #1</strong></td>
<td><strong>Parent/Guardian #2</strong></td>
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# Emergency Contacts Information

**Student Name:** __________________________________________  **School:** ____________________________________________

Are there legal situations regarding the student of which QSD needs to be aware of:  □ Yes  □ No

1. Is there a joint-custody or parenting plan in effect?  □ Yes or □ No  
   (If yes, plan must be on file with the school for enforcement)

2. Is there a restraining order in effect?  □ Yes or □ No  
   If so, restraining order is against: _____________________________

## Siblings attending Quincy School District

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>AGE</th>
<th>SCHOOL</th>
<th>GRADE</th>
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**DOES STUDENT ATTEND CHILD CARE?**  □ Before School  □ After School  □ Before and after School

**DAYCARE PROVIDER NAME:** ____________________________________  **PRIMARY PHONE:** ________________________________  **PHONE #2:** ________________________________

**DAYCARE PROVIDER ADDRESS:** ________________________________  **( )__ _______________  ( ) ________________

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 cannot reach a parent/guardian, please list persons you trust who are available during the day to provide care for your child.

**PRIMARY CONTACT (other than parent/guardian)**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>RELATIONSHIP TO CHILD</th>
<th>PHONE #1</th>
<th>PHONE #2</th>
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<td>□ Home</td>
<td>□ Work</td>
</tr>
</tbody>
</table>

**PRIMARY CONTACT ADDRESS**  Street  City  State  ZIP

**ADDITIONAL CONTACT (other than parent/guardian)**

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**ADDITIONAL CONTACT ADDRESS**  Street  City  State  ZIP

**ADDITIONAL CONTACT (other than parent/guardian)**

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<td></td>
<td></td>
<td>□ Home</td>
<td>□ Work</td>
</tr>
</tbody>
</table>

**ADDITIONAL CONTACT ADDRESS**  Street  City  State  ZIP

1. Is your family in a temporary living arrangement due to loss of housing or economic hardship?  □ Yes or □ No

**STUDENT RELEASE AUTHORIZATION/EMERGENCY:**

► In the event that the school is unable to contact the parent/guardian, I authorize that my child/children may be released to the person(s) listed above. 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 be caused for revocation of the student’s enrollment or assignment to a school in the Quincy School District.

► If I cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send my child (properly accompanied) for treatment to the hospital or doctor most easily accessible.

**Legal Parent/Guardian Signature** ____________________________  **Date** __________________

*Only individuals listed on this form will be allowed to check out student from school.*
School districts in Washington State are required to report student data by ethnicity and race categories to the state’s Office of Superintendent of Public Instruction. Ethnicity and race categories used in our district are the same as used in all Washington school districts. They are set by the federal government, the Washington State Legislature, and the state Superintendent of Public Instruction.

Please answer questions 1 and 2:
(Even if you answer “yes” to question 1 also answer question 2.)

1. Is your child of Hispanic or Latino origin?
   - No, my child is not Hispanic or Latino
   - Yes, my Child is Hispanic or Latino - (Check all that apply):
     - Cuban
     - Central American
     - South American
     - Dominican
     - Puerto Rican
     - Latin American
     - Spaniard
     - Mexican/Mexican American/Chicano
     - Other Hispanic/Latino

2. What race do you consider your child?
   (Check all that apply being sure to select at least one. If one parent identifies with one race and the other parent with another, you will be able to check both races for your child.)
   - African American or Black
   - Native Hawaiian
   - Nisqually Nooksack
   - White or Caucasian
   - Fijian
   - Port Gamble S’Klallam
   - Asian Indian
   - Guamanian/ Chamorro
   - Puyallup
   - Cambodian
   - Mariana Islander
   - Quileute
   - Chinese
   - Micronesia
   - Quinault
   - Filipino
   - Samoan
   - Samish
   - Hmong
   - Tongan
   - Sauk-Suiattle
   - Indonesian
   - Other Pacific Islander
   - Shoalwater Bay
   - Japanese
   - Alaska Native
   - Skokomish
   - Korean
   - Other Asian
   - Snoqualmie
   - Laotian
   - Chehalis
   - Spokane
   - Malaysian
   - Colville
   - Squax Island
   - Pakistani
   - Cowlitz
   - Stillaguamish
   - Singaporean
   - Hoh
   - Suquamish
   - Taiwanese
   - Jamestown S’Klallam
   - Swinomish
   - Thai
   - Kalispel
   - Tulalip
   - Vietnamese
   - Lower Elwa Klallam
   - Yakama
   - Other American Indian
   - Lower Elwa Klallam
   - Tribe/Alaska Native

Signature______________________________Date______Relationship________

PLEASE ANSWER QUESTIONS #1 AND #2. THANK YOU.
Dear Parent or Guardian:

Each year, school districts in Washington are required to report student data by ethnicity and race categories to the state’s Office of Superintendent of Public Instruction (OSPI). Ethnicity and race categories used in our district are the same as are used in all Washington school districts. They are set by the federal government, the Washington State Legislature, and OSPI. OSPI is required to report the total number of students in various categories in each school to the federal government, but it does not report individual student data. These reports help our district and the state keep track of changes in student enrollment and various outcomes (such as graduation rates) to ensure that all students receive the educational programs and services to which they are entitled.

Recently, the federal government and OSPI changed the reporting categories for student ethnic and race data. As a result of the new reporting categories, we need to ask you to identify your child as either Hispanic/Latino or not Hispanic/Latino and by one or more racial groups. Washington has 57 racial categories to choose from.

If your family is Asian, you will now be able to list your child as Chinese, Japanese, or belonging to one or more of the other Asian groups. If your family is Native American, you will be able to list your child’s tribal affiliation. If one parent identifies with one race and the other parent with another, you will be able to check both races for your child.

For more information about the student data reporting categories, please see: http://www.k12.wa.us/CEDARS/default.aspx.

Sincerely,

John Boyd
Superintendent
Student Name: | Date: 
---|---

Birth Date: | Gender: | Grade: | SSID: 
---|---|---|---

Form Completed by:

Parent/Guardian Name | Relationship to Student 
---|---

Parent/Guardian Signature 

If available, in what language would you prefer to receive communication from the school? 

Did your child receive English language development support through the Transitional Bilingual Instruction Program in the last school your child attended?  Yes | No | Don’t Know

1. In what country was your child born? 

2. **What language did your child first learn to speak?** 

3. **What language does YOUR CHILD use the most at home?** 

4. What language(s) do parent/guardians use the most when you speak to your child? 

5. Has your child ever attended a school outside of the United States?  
   | Yes | No 
   ___ | ___ 
   
   If yes, in what language(s) was instruction given? 
   
   For how many months?  

6. Has your child attended school in the United States before enrolling in this district?  
   (Kindergarten – 12th grade)  
   | Yes | No 
   ___ | ___ 
   
   For how many months?  

   *One (1) school year = 10 months*

7. Do grandparent(s) or parent(s) have a tribal affiliation?  
   | Yes | No 
   ___ | ___

*WAC 392-160-005: “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.*

April 2013
<table>
<thead>
<tr>
<th>Nombre del alumno:</th>
<th>Fecha:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Fecha de nacimiento:</th>
<th>Sexo:</th>
<th>Año escolar:</th>
<th>Número estatal de identificación del alumno:</th>
</tr>
</thead>
</table>

Este formulario fue completado por:

Nombre del padre/madre/tutor: ________________________  Relación con el alumno: ________________________
Nombre del padre/madre/tutor: ________________________

Si está disponible, ¿en qué idioma desea recibir información de la escuela?

¿Su hijo recibió apoyo para el aprendizaje del idioma inglés a través del Programa Estatal de Educación Bilingüe de Transición en la última escuela a la que asistió?  Sí  No  No sé  

1. ¿En qué país nació su hijo? _______________

2. ¿Qué idioma aprendió su hijo primero?* _______________

3. ¿Qué idioma usa más SU HIJO en casa?* _______________

4. ¿Qué idioma(s) usan más los padres/tutores cuando hablan con su hijo? _______________

5. ¿Alguna vez asistió su hijo a la escuela fuera de los Estados Unidos?  _____Sí  _____No
   En caso afirmativo, ¿en qué idioma se le dio la instrucción? ______________  ¿Por cuántos meses? ______

6. ¿Alguna vez asistió su hijo a la escuela en los Estados Unidos antes de matricularse en este distrito escolar? (Kinder a 12.º grado)  _____Sí  _____No
   ¿Por cuántos meses? ______
   *Un (1) año escolar equivale a 10 meses

*WAC 392-160-005: "Idioma principal" significa el idioma que el alumno usa con más frecuencia (no necesariamente el idioma que usan los padres, tutores u otros) para comunicarse en el lugar donde vive el alumno.
Name of Student: ___________________________ Grade _____

1. Does your child have any history of placement in Special Education programs?  Yes ____ No ____

If yes, explain the type of program: _______________________________________________________________
________________________________________________________________________________________

2. Is your child under a current suspension from his/her previous school?  Yes ____ No ____

3. Has your child ever been suspended from a public school?  Yes ____ No ____
If yes, please explain ________________________________________________________________________

(Suspended means a suspension for any portion of school day)

4. Has your child ever been expelled from a public school?  Yes ____ No ____
If yes, please explain: ______________________________________________________________________

(Expulsion means a denial of attendance at any single subject or class or full day schedule or a denial of attendance at any other type of activity conducted by or in behalf of the school district for an indefinite period of time.)

5. Does your child have any unpaid fees or fines imposed by other schools?  Yes ____ No ____
If yes, please explain _______________________________________________________________________

6. Does your child have any health conditions affecting his/her educational needs?  Yes ____ No ____
If yes, please explain _______________________________________________________________________

I, ___________________________ certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct and the undersigned is the true and legal guardian of named student.

Parent/Guardian signature ______________ Date __________

Please print name: ___________________________
Student Name | School | Grade
---|---|---
| Quincy High School | 9 10 11 12 |

**Student Injuries and Insurance**
I understand that the school does not provide medical insurance for student injuries but does make voluntary student insurance available. I have received the information regarding this program.

- [ ] I will enroll my child in the program (REQUIRES RETURN OF COMPLETED STUDENT INSURANCE PACKET).
- [ ] I will not enroll my child in the program.

_________  __________
Parent /Guardian Signature  Date

**Publication Policy**
The Family Educational Rights & Privacy Act is posted in each school office for your review. The Family Education Rights and Privacy Act grant a parent the right to restrict the release of student information. If a written request is placed in a student’s record, information will not be released except in an extreme emergency to protect the student’s health and safety. The student’s name will not appear in directories, school programs, yearbook, newspaper, or other public news media. Those families who have unlisted telephone numbers may request that those numbers not be released without prior consent.

Student information is used for state reporting and funding, contacting families in emergency situations and mailing of correspondence. If you should have any concerns about this issue, please contact the building principal where your child attends school.

- [ ] I give permission for my child to be photographed.
- [ ] I do not wish to have my child photographed.

_________  __________
Parent /Guardian Signature  Date

**Weapon Free/Drug Free Policy and District Harassment Policy**
- Quincy School District’s property is a weapon-free zone.
- I also understand that Quincy School District must comply with Federal regulations relating to the Drug Free Workplace Act and the Drug Free Schools and Communities Act. This means that there are no drugs, alcohol or tobacco allowed on school district premises or events by anyone.
- The Quincy School District holds a zero tolerance policy with regard to harassment, intimidation and bullying.

As a parent/guardian, I will do my best to enforce the policies stated above.

_________  __________
Parent /Guardian Signature  Date
2014-2015
QUINCY SCHOOL DISTRICT
STUDENT HEALTH INFORMATION
*This form must be completed for each new school year.

Name: ____________________________ Birthdate: ____________ Sex: M/ F
  Last First MI

School: Quincy High School Grade: ____________ Date: ____________

Doctor: ____________________________ Phone: ______________________

ALERT TO PARENTS/GUARDIANS: If your child has a LIFE THREATENING HEALTH CONDITION (as indicated below), it is vital that you share this information. The school nurse must have this information before your child starts school.

LIFE THREATENING HEALTH CONDITIONS
☐ My child has none of the life threatening health conditions listed below.
☐ Asthma: What causes the asthma? ____________________________ ☐ Uses inhaler ☐ Needs inhaler at school
☐ Allergy, Severe (with EpiPen prescription): ☐ Bee sting ☐ Food: ______________ ☐ Latex ☐ Other: ______________
☐ Diabetes: Age of diagnosis: ____________ ☐ Type I ☐ Type II ☐ Uses Insulin ☐ Oral Medication
☐ Seizure disorder: Date of last seizure: ______________ ☐ Uses seizure medication
☐ V/P Shunt (in brain) ☐ Cardiac arrhythmia or other cardiac problems which require activity restrictions?
☐ Hemophilia/Other blood disorder ____________________________

MEDICATION
Does your child take any medication? ☐ No ☐ Yes, name of medication: ____________________________
Will medication be needed at school? ☐ No ☐ *Yes, name of medication: ____________________________

*If your child needs medication at school, a "Medication Authorization" form is required every year before any medication may be given. This form is available from the school office or on the district website at www.qsd.wednet.edu.

NON-LIFE THREATENING HEALTH CONDITIONS
☐ Vision concerns? ☐ Glasses ☐ Contacts ☐ Other: ____________________________
☐ Hearing concerns? ☐ Wears hearing aids
☐ History of Concussion(s): Age(s) ____________________________ Was a doctor seen? ____________
☐ Other: ____________________________

Please list any other significant health concerns that the school nurse should know about (allergies, surgeries, hospitalizations, disorders, mental health disorders such as ADHD, autism, depression, anxiety, etc.)

AUTHORIZATION FOR SHARING HEALTH INFORMATION/ACCESSING MEDICAL CARE
As parent/guardian, I agree to notify the school about any significant change in my child’s health status. I also understand that this information will be accessible to the following people: School nurses, teachers, specialists, office staff and emergency medical personnel.

If I cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send my child (properly accompanied) for treatment to the hospital or doctor most easily accessible.

Date ____________________________ Parent or legal guardian signature ____________________________

05/07/14
**Certificate of Immunization Status (CIS)**

DOH 348-013 January 2010

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

<table>
<thead>
<tr>
<th>Child’s Last Name:</th>
<th>First Name:</th>
<th>Middle Initial:</th>
<th>Birthdate (mm/dd/yyyy):</th>
<th>Sex:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symbols below:</strong></td>
<td><strong>Required for School and Child Care/Preschool</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Required for Child Care/Preschool Only</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parent/Guardian Name (please print):</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required  Date

Symbols below: ◆ Required for School and Child Care/Preschool  ● Required for Child Care/Preschool Only

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B (Hep B)</strong></td>
<td>1</td>
<td>Month Day Year</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>or Hep B - 2 dose alternate schedule for teens</strong></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Rotavirus (RV1, RV5)</strong></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</strong></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Tetanus, Diphtheria, Pertussis (Td, TdP)</strong></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Haemophilus influenzae type b (Hib)</strong></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Pneumococcal (PCV, PPSV)</strong></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Influenza (flu, most recent)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Measles, Mumps, Rubella (MMR)</strong></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Varicella (chickenpox) or verify disease 1-4</strong></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis A (Hep A)</strong></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Meningococcal (MCV, MPSV)</strong></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Human Papillomavirus (HPV)</strong></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

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: __________________________

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

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).

**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.

- Diphtheria
- Mumps
- Polio
- Rubella
- Other:
- Tetanus
- Measles
- Varicella

Licensed health care provider (HCP) Signature  Date (MD, DO, ND, PA, ARNP)

HCP Printed Name: __________________________

**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

Office Use Only: Immunization information updated and verified with parent/guardian permission.
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):

#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, 2011, fill in as shown here ►

#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 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.

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**Reference Guide**

**Abbreviations**

- DT: Diphtheria, Tetanus
- DTaP: Diphtheria, Tetanus, Pertussis
- DTP: Diphtheria, Tetanus, acellular Pertussis
- Flu: Influenza
- HBG: Hepatitis B Immune Globulin

**Trade Name Trade Names in alphabetical order**

<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Vaccine</th>
<th>Trade Name</th>
<th>Vaccine</th>
<th>Trade Name</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>ActHIB</td>
<td>Hib</td>
<td>Engerix-B</td>
<td>Hep B</td>
<td>Ipol</td>
<td>IPV</td>
</tr>
<tr>
<td>Adacel</td>
<td>Tdap</td>
<td>Fluarix</td>
<td>Flu (TIV)</td>
<td>Infanrix</td>
<td>DTaP</td>
</tr>
<tr>
<td>Affuria</td>
<td>Flu (TIV)</td>
<td>FluLaval</td>
<td>Flu (TIV)</td>
<td>Kanrix (Krka)</td>
<td>DTaP + IPV</td>
</tr>
<tr>
<td>Boostrix</td>
<td>Tdap</td>
<td>FluMist</td>
<td>Flu (LAIV)</td>
<td>Menactra</td>
<td>MCV or MCV4</td>
</tr>
<tr>
<td>Cervarix</td>
<td>HPV2</td>
<td>Fluvarin</td>
<td>Flu (TIV)</td>
<td>Menomune</td>
<td>MPSV or MPSV</td>
</tr>
<tr>
<td>Convax (Cmvx)</td>
<td>Hep B + Hib</td>
<td>Fluzone</td>
<td>Flu (TIV)</td>
<td>Pediatrix (Pdxr)</td>
<td>DTaP + Hep B + IPV</td>
</tr>
<tr>
<td>Daptacel</td>
<td>DTaP</td>
<td>Gardasil</td>
<td>HPV4</td>
<td>PedvaxHB</td>
<td>Hib</td>
</tr>
<tr>
<td>Decavac</td>
<td>Td</td>
<td>Havrix</td>
<td>Hep A</td>
<td>Pentacel (Pncl)</td>
<td>DTaP + Hep B + IPV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RotaTeq</td>
<td>RotaV5</td>
</tr>
</tbody>
</table>

**Abbreviations**

- DT: Diphtheria, Tetanus
- DTaP: Diphtheria, Tetanus, Pertussis
- DTP: Diphtheria, Tetanus, acellular Pertussis
- Flu: Influenza
- HBG: Hepatitis B Immune Globulin

**Abbreviations**

- MCV or MCV4: Meningococcal Conjugate Vaccine
- IPV: Inactivated Poliovirus Vaccine
- OPV: Oral Poliovirus Vaccine
- PCV or PCV7 or PCV13: Pneumococcal Conjugate Vaccine
- PPSV or PPV23: Pneumococcal Polysaccharide Vaccine
- TIG: Tetanus Immune Globulin

**Full Vaccine Name**

- Meningococcal Polysaccharide Vaccine
- Measles, Mumps, Rubella / with Varicella
- Oral Poliovirus Vaccine
- Pneumococcal Conjugate Vaccine
- Pneumococcal Polysaccharide Vaccine
- Tetanus Immune Globulin

**Abbreviations**

- Rota (RV1 or RV5): RotaVirus
- Td: Tetanus, Diphtheria
- Tdap: Tetanus, Diphtheria, acellular Pertussis

**Abbreviations**

- HBG: Hepatitis B Immune Globulin
- MCV or MCV4: Meningococcal Conjugate Vaccine
- PPSV or PPV23: Pneumococcal Polysaccharide Vaccine

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