

Student Registration Packet

Hard copies of the forms in this packet should be turned in to your neighborhood school. You may indicate at that time if you wish to attend a different location.



DO NOT WRITE IN SHADED AREA – FOR OFFICE USE ONLY

Other ID#	Grade	WA Grad Yr	Entry Date	Entry Code	Records Requested Y N	Waivered From	Overflowed From	Teacher	Tech Notified Y N	KNG Placement R B FD
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(Please Print)

Student Information

Student Legal Last Name _____ **Student Legal** First Name _____

Student Legal Middle _____ Gender Male Female Grade _____

Birthdate (Month/Day/Year) _____ Birthplace (City/State/Country) _____

Has your child ever been registered in the Sumner School District? Yes No If yes, what school _____

Has your child ever attended school under a different name? If yes, what name(s) _____

Language student currently speaks English Spanish Korean Tagalog Ukrainian Russian Other _____

First language spoken by the student English Spanish Korean Tagalog Ukrainian Russian Other _____

Language student speaks at home English Spanish Korean Tagalog Ukrainian Russian Other _____

Household #1 - Parent/Guardian #1

Last Name _____ First Name _____

Street Address _____ Apt# _____ City, State, ZIP Code _____

Mailing Address/PO Box _____ City, State, ZIP Code _____
(Complete if different than street address)

Relationship to Student Father Mother Guardian Other _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____ Ext: _____
Please check if unlisted

Primary contact phone number (check one) home cell work e-mail _____

Household #1 - Parent/Guardian #2

Last Name _____ First Name _____

Relationship to Student Father Stepfather Mother Stepmother Guardian Other _____

Cell Phone (____) _____ Work Phone (____) _____ Ext: _____ e-mail _____

Household #2 - Parent/Guardian #1

Last Name _____ First Name _____

Street Address _____ Apt# _____ City, State, ZIP Code _____

Mailing Address/PO Box _____ City, State, ZIP Code _____
(Complete if different than street address)

Relationship to Student Father Mother Guardian Other _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____ Ext: _____
Please check if unlisted

Primary contact phone number (check one) home cell work e-mail _____

Household #2 - Parent/Guardian #2

Last Name _____ First Name _____

Relationship to Student Father Stepfather Mother Stepmother Guardian Other _____

Cell Phone (____) _____ Work Phone (____) _____ Ext: _____ e-mail _____

Student History

Name of school student last attended _____ District _____ City _____ State _____

Has your child ever been retained? Yes No If yes, at what grade level(s)? _____

Has your child ever received services in any of the following programs? Check all applicable programs.

Special Education 504 Accommodations Highly Capable ELL Title 1 Services LAP Services Migrant Services

Name of school where services were received _____

Does your child have any past, current, or pending disciplinary actions or any history of violent behavior? Yes No Date _____

Is your child presently on suspension or expulsion from another school? Yes No If yes, reason _____

Is there a joint-custody or parenting plan in effect? Yes No If yes, a certified copy of the most recent plan must be on file with the school for enforcement.

Is there a restraining order against anyone pertaining to your student? Yes No If yes, most recent certified legal papers must be on file with the school for enforcement. Restraining order is against Mother Father Other _____

Emergency Contacts

Name (other than guardian) _____ Relationship to Student _____

Phone number (____) _____ home cell work

Name (other than guardian) _____ Relationship to Student _____

Phone number (____) _____ home cell work

Name (other than guardian) _____ Relationship to Student _____

Phone number (____) _____ home cell work

Name (other than guardian) _____ Relationship to Student _____

Phone number (____) _____ home cell work

Childcare

Does student attend childcare? Before school Afterschool Before and afterschool

Provider's name _____ Phone Number (____) _____

Street Address _____ City, State, ZIP Code _____

Siblings

Legal Last Name _____ Legal First Name _____ School _____ Grade _____

Legal Last Name _____ Legal First Name _____ School _____ Grade _____

Legal Last Name _____ Legal First Name _____ School _____ Grade _____

Legal Last Name _____ Legal First Name _____ School _____ Grade _____

Release of Information

I give permission for my child's photograph/video to be taken by district employees or members of the media. Yes No

I give permission for my name, phone number and e-mail to be given to parent support group for projects. Yes No

I give permission for my name and phone number to be used by parent support group for an emergency phone tree. Yes No

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 be cause for revocation of the student's enrollment or assignment to a school in the Sumner School District.

Parent/Guardian Signature _____ Date _____

Equal Opportunity

The Sumner School District complies with all federal and state rules and regulations and does not discriminate on the basis of race, color, national origin, gender, or disability in education programs, services and activities. Inquiries regarding compliance and/or grievance procedures may be directed to the school district's Title IX/RCW 28A.640 officer and/or Section 504/ADA coordinator, in writing at 1202 Wood Avenue, Sumner, or by telephone (253) 891-6000.



Health History Form

Student: _____ School: _____ Grade: _____

Sex: M F Birthday: _____ Age: _____ Current Medications: _____

Parent/Guardian Name: _____

Address: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Dear Parent and/or Guardian:

Please describe your child's health problems on this form. It is important to keep school personnel informed of any changes in health conditions or medication that could affect your child's school performance.

ALLERGY <input type="checkbox"/> Drug <input type="checkbox"/> Food <input type="checkbox"/> Insect <input type="checkbox"/> Other	Anaphylactic: <input type="checkbox"/> yes <input type="checkbox"/> no Describe Reaction:
ASTHMA/RESPIRATORY PROBLEM Cystic Fibrosis, etc.	Type: Special Needs:
BLOOD DISEASE Anemia, Hemophilia, etc	Type: Special Needs:
CARDIAC Pacemaker, arrhythmia	Type: Limitations
DIABETES	Medication: Special Needs:
DIGESTIVE DISORDER Food Intolerance, etc.	Type: Special Needs:
HEARING IMPAIRMENT OR COMPLETE LOSS	Describe: Special Needs:
CANCER	Type: Special Needs:
NEUROLOGICAL PROBLEM Hydrocephalus, Cerebral Palsy, etc.	Type: Special Needs:
SEIZURE DISORDER Epilepsy, etc.	Type: Medication: Special Needs:
ORTHOPEDIC PROBLEM	Type: Surgeries: Limitations:
URINARY/KIDNEY DISORDER Nephritis, Kidney stones, etc,	Type: Special Needs:
VISION IMPAIRMENT OR COMPLETE LOSS	Describe: Special Needs:
SERIOUS ILLNESSES/INJURIES	Describe: Special Needs:
SKIN PROBLEMS Eczema, etc.	Describe: Special Needs:
OTHER HEALTH PROBLEMS	Describe: Special Needs:

My child has none of the above conditions to my knowledge.

Please circle the above condition(s), if any, that is life threatening.

RCW 28A.210 requires physician orders and a nursing care plan in place before a student attends school.

AUTHORIZATION FOR EMERGENCY PROCEDURE

If the parents or guardian on the registration record cannot be reached at the time of a serious illness or injury, school authorities have my permission to seek necessary emergency treatment. If school authorities determine urgent or emergent care is needed, I authorize and direct the school authorities to take my child (properly accompanied) to the hospital or doctor most easily accessible. I understand that I will assume full responsibility for the payment of any services rendered. Yes No

Date: _____

Parent/Guardian Signature: _____

Allergic Reaction Response Plan

In the event your child experiences an allergic reaction (i.e. to bee stings, foods, medications) at school or on a field trip, school personnel will respond in the following manner:

1. The student's condition will immediately be assessed and first aid care given as needed.
2. If indicated, 911 will be called.
3. If permission for medication for a severe allergic reaction is on file, complete, and current, medication will be administered according to orders.
4. Attempts will be made to immediately notify parents/guardians or emergency contacts of allergic reaction.
5. If direction regarding emergent care is required and attempts to contact above persons have failed, student will be evaluated and transported by Emergency Medical Service.
6. If parents/guardians or emergency contacts are not available for consultation, student will be transported to Emergency Room with Emergency Medical Service recommendation. Attempts to contact parent/guardians or emergency contacts will continue until successful.

School Medication Policy

The administration of medications at school is a service the Sumner School District provides. By state law, RCW 28A.31.150, written permission from parent and physician must be provided before medications can be administered at school. Renewal of written permission must be completed at the beginning of each school year and whenever the physician adjusts a prescription. The intent of the state law concerning medication administration at school obligates school districts to obtain written physician and parental permission for both prescription and over-the-counter medications (i.e. Tylenol, medicated throat lozenges, vitamins).

For safety reasons, medications cannot be transported with students between home and school. Medication must be transported by an adult and be in the original container with a prescription label. Students are not to carry medications with them at school unless it is medically necessary to do so and written permission from parent and physician to carry at school is on file.

Your assistance in maintaining a safe medication administration routine for your child/children in the school setting is greatly appreciated. Please feel free to contact the health technician at your child's school should you have any questions or concerns.



VACCINES REQUIRED FOR SCHOOL ATTENDANCE, GRADES K-12

July 1, 2011 – June 30, 2012

Documentation of all vaccines received must include **Month, Day & Year**.

VACCINE	Kindergarten	1 st -3 rd Grade	4 th -5 th Grade	6 th Grade	7 th -10 th Grade	11 th -12 th Grade
HEPATITIS B (Hep B) <ul style="list-style-type: none"> Dose 2 ≥4 weeks after dose 1 Dose 3 ≥8 weeks after dose 2 Dose 3 ≥ 16 weeks after dose 1 Dose 3 ≥ 6 months of age 	Required: 3 doses Acceptable: 2 doses of an adolescent vaccine (Recombivax HB®), <u>IF</u> given between ages 11 and 15 AND doses separated by ≥4 months.					
DIPHTHERIA, TETANUS AND PERTUSSIS (DTaP/DT/Td/Tdap) <ul style="list-style-type: none"> DTaP: for children through age 6. Td: for children on or after the 7th birthday. Tdap: for children on or after the 11th birthday. 	Required: 5 doses, <u>IF</u> child received dose 5 on or after the 4 th birthday. Acceptable: 4 doses DTaP/DT <u>IF</u> child got dose 4 on or after the 4 th birthday.	Required: 5 doses, <u>IF</u> child got dose 5 on or after the 4 th birthday. Required: 1 dose Tdap for 6th-10th grade <u>IF</u> student is ≥11 years old. Acceptable: <ul style="list-style-type: none"> 4 doses DTaP/DT <u>IF</u> child got dose 4 on or after the 4th birthday. 3 doses diphtheria and tetanus containing vaccines may complete the series for children ≥7 years of age. 				
POLIO (IPV or OPV) <ul style="list-style-type: none"> Not required for students 18 years and older. 	Required: 4 doses, <u>IF</u> child got dose 4 on or after the 4 th birthday AND dose 3 and 4 separated by ≥6 months. Acceptable: 3 doses <u>IF</u> child got last dose on or after the 4 th birthday.	Required: 4 doses <u>IF</u> child got all doses before the 4 th birthday. Acceptable: 3 doses <u>IF</u> child got last dose on or after the 4 th birthday.				
MMR (MMR or MMRV)	Required: 2 doses <u>IF</u> child got dose 1 on or after the 1 st birthday AND dose 2 at least ≥28 days later. (4-day grace <u>DOES</u> apply between doses of the same live vaccine such as MMR/MMR or MMRV/MMRV).					
VARICELLA (VAR or MMRV) <ul style="list-style-type: none"> Varicella: must get the same day as MMR <u>OR</u> ≥ 28 days apart. (4-day grace <u>DOES NOT</u> apply). 	Required: 2 doses Child must get dose 1 on or after the 1 st birthday AND dose 2 given ≥3 months later. Acceptable: <ul style="list-style-type: none"> Health care provider verification of disease. ≥28 days between doses. 	Required: 1 dose Child must get dose 1 on or after the 1 st birthday. Acceptable: Parent-reported history of disease.	Recommended, but not required.			

- See the **Minimum Age and Interval Table** on page 2 for recommended minimum age and spacing information.
- **Acceptable for all vaccines:** blood test showing proof of immunity – must have health care provider’s signature **AND** attached lab report(s).
- A vaccine series never needs to be restarted if the time between doses is longer than the recommended interval.
- **Valid:** vaccine doses given up to 4 days before the minimum age or interval (4 day grace period).
- The 4 day grace period **DOES** apply between dose 1 and dose 2 of the same live vaccines, such as between MMR and MMR, **BUT NOT** between MMR and MMRV.
- The 4 day grace period **DOES NOT** apply between dose 1 and dose 2 of different live vaccines, such as between MMR and Varicella or between MMR and live flu vaccine.

If you have a disability and need this document in another format, please call 1-800-322-2588 (711 – TTY relay).

Minimum Age & Interval for Valid Vaccine Doses

Vaccine	Dose #	Minimum Age	Minimum Interval Between Doses	Notes
Hepatitis B HepB	Dose 1	Birth	4 weeks between Dose 1 & 2	<ul style="list-style-type: none"> ▪ Minimum interval for Recombivax HB®: ≥4 months. ▪ Complete series within 9 months of starting school. ▪ DO NOT complete series in less than 4 months.
	Dose 2	4 weeks	8 weeks between Dose 2 & 3	
	Dose 3	24 weeks	16 weeks between Dose 1 & 3	
Diphtheria, Tetanus, and Pertussis DTaP/DT	Dose 1	6 weeks	4 weeks between Dose 1 & 2	<ul style="list-style-type: none"> ▪ Typical vaccine schedule: 2, 4, 6, and 15-18 months of age. If child got dose 4 before the 4th birthday, child must get dose 5 at 4-6 years of age. Dose 5 not required if child got dose 4 on or after the 4th birthday. ▪ Recommended 6 months between dose 3 and dose 4, but ≥4 months is acceptable.
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	6 months between Dose 3 & 4	
	Dose 4	12 months	6 months between Dose 4 & 5	
	Dose 5	4 years	–	
Tetanus, Diphtheria, and Pertussis Tdap	Dose 1	10 years (minimum age for Tdap depends on vaccine brand)	–	<ul style="list-style-type: none"> ▪ Boostrix®: licensed for 10 year olds. ▪ Adacel®: licensed for 11 year olds.
Tetanus and Diphtheria Td	Dose 1	7 years	5 years	
Polio IPV or OPV	Dose 1	6 weeks	4 weeks between Dose 1 & 2	
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	6 months between Dose 3 & 4	
	Dose 4	4 years	–	
Measles, Mumps, and Rubella MMR	Dose 1	12 months	4 weeks between Dose 1 & 2	<ul style="list-style-type: none"> ▪ MMRV (MMR + varicella) may be used in place of separate MMR and varicella vaccines. ▪ Child must get MMR, Varicella, and MMRV doses on the same day or at least ≥28 days apart. ▪ 4 day grace period can be used between 2 doses of MMR as long as child does not get varicella or MMRV during that time.
	Dose 2	13 months	–	
Varicella (chickenpox) VAR	Dose 1	12 months	3 months between Dose 1 & 2	<ul style="list-style-type: none"> ▪ Child must get MMR and varicella doses on the same day or at least ≥28 days apart. ▪ Recommended: 3 months between varicella doses for children on or before the 13th birthday, but ≥28 days is acceptable.
	Dose 2	15 months	–	

Find information on other recommended vaccines not required for school entry on the Recommended Immunization Schedules: <http://www.immunize.org/cdc/schedules/>

If you have a disability and need this document in another format, please call 1-800-322-2588 (711 – TTY relay).



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

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

DOH 348-013 January 2010

2010-01-13 05:10



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 _____ Address 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.
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Your child may be eligible for additional educational services through Title X, Part C, Federal McKinney-Vento Assistance Act. This form is required by OSPI and being sent to all parents and guardians to help determine eligibility. **Questions?** Call the STARR Project at (253) 891-6066, or the Homeless Education Coordinator at (253) 891-6537.

Please answer the questions below and return the form to your child’s school office.

Name of Student: _____ Name of School: _____

Birth Date: _____ Age: _____ Grade: _____ Sex: Male Female

I rent/own my own home or apartment:

Yes

If yes, please go to Section B at the bottom of the form and provide a signature.

No

If no, please fill out Section A of this form to help us determine services your child may be eligible to receive.

Section A: Please check the box that best explains your current living arrangements.

- Temporarily sharing the housing of others due to loss of housing, economic hardship or similar reason
- Live with an adult that is not a parent or legal guardian; or youth living alone without an adult
- Currently staying in a hotel/motel due to lack of alternative housing
- In a vehicle of any kind, RV Park, campground, or abandoned building
- In an emergency or transitional shelter, foster care, transitional housing, or other setting designed to provide temporary living accommodations
- Other, please describe: _____

Current Address: _____ Phone Number: _____

Contact Name: _____ Contact Number: _____

Section B: The undersigned certifies that the information provided above is accurate.

Please print name of parent/legal guardian or unaccompanied youth: _____

Signature of parent/legal guardian or unaccompanied youth: _____

ATTN School Staff: Please send this questionnaire to the STARR Project – Central Office.
For Central Office Use Only: Date Received: _____; Initials: _____; Referral to School BPC: _____
Follow Up Comments: _____