

Enrollment Application



An Equal Opportunity Provider

Name: _____
First Last Middle

Name Used (if different): _____ Age: _____ Birthdate: _____

Attendance: Full Time Part Time

Parent/Guardian Name:	Parent/Guardian Name:
Lives With: Full Time <input type="checkbox"/> Part Time <input type="checkbox"/>	Lives With: Full Time <input type="checkbox"/> Part Time <input type="checkbox"/>
Home Address: ----- -----	Home Address: ----- -----
Cell/Home Number: -----	Cell/Home Number: -----
Phone Carrier:	Phone Carrier:
Work: -----	Work: -----
Work Phone #: -----	Work Phone #: -----
Work Address: ----- -----	Work Address: ----- -----
Email Address:	Email Address:

Typical Daily Schedule

Monday: From _____ To _____
 Tuesday: From _____ To _____
 Wednesday: From _____ To _____
 Thursday: From _____ To _____
 Friday: From _____ To _____

Who **DOES NOT** have permission to pick up your child?

Parent Signature

Date

Emergency Contacts

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone Number: _____	Phone Number: _____
<input type="checkbox"/> Lives With <input type="checkbox"/> Emergency <input type="checkbox"/> Pick Up	<input type="checkbox"/> Lives With <input type="checkbox"/> Emergency <input type="checkbox"/> Pick Up
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone Number: _____	Phone Number: _____
<input type="checkbox"/> Lives With <input type="checkbox"/> Emergency <input type="checkbox"/> Pick Up	<input type="checkbox"/> Lives With <input type="checkbox"/> Emergency <input type="checkbox"/> Pick Up

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

↓INITIAL↓

I, hereby give permission that my child _____ may be given emergency treatment by a qualified childcare provider at Lil Hawks. When I cannot be contacted, I authorize and consent to medical, surgical, and hospital care, treatment, and procedures to be performed for my child by a licensed physician, health care provider, hospital, or aid car attendant when deemed necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment.

If myself and/or any of my emergency contacts are unreachable, I authorize my child to be released back into the care of Lil' Hawks.

I Understand that Lil' Hawks is not responsible for any costs involved in the care, transport, or treatment of my child

Medical Insurance

Insurance Company Name

Policy Holder's Name:

Member/Policy Number:

Secondary Medical Insurance

Insurance Company Name

Policy Holder's Name:

Member/Policy Number:

Parent Signature

Date

Health Information

My Child's Medical Provider	My Child's Dental Provider
Name and Address:	Name and Address:
Phone Number:	Phone Number:
Date of Last Physical Exam:	Date of Last Dental Exam:

My child's allergies (Please include side-effects and/or reactions)	My Child's Current Medications <small>*Medication to be given in our care will require a separate form.*</small>

Other Medical or Health Information we need to know (special health needs)	Toothbrushing Policy
	According to Washington Administrative Code 110-300-0180: At least once per day, an early learning provider must offer children an opportunity for developmentally appropriate tooth brushing activities. We, here at Lil' Hawks are OPTING OUT of this policy.
	↓INITIAL↓ I acknowledge that Lil Hawks is opting out of the toothbrushing policy as outlined above.

Fluid Milk Substitution

Lil Hawks provides a non-dairy milk substitute of SOY MILK for children with special dietary needs. Soy Milk provided is nutritionally equivalent to fluid milk and meets the nutritional standards set by the U.S. Department of Agriculture for Child Nutrition Programs in order for the facility to claim reimbursement for the meal through the Child and Adult Care Food Program (CACFP)

Given this information, please initial one of the boxes below

	My child does not have special dietary needs, and does not require a milk substitution.
	My child needs to be given the center provided Soy Milk, as provided by Lil' Hawks due to a medical or special dietary need.
	I will provide a non-dairy beverage for my child. I understand that the center cannot claim meals that require milk unless I get a written statement from a recognized medical authority.

If special dietary need is selected, please identify the reason: _____

Financial Agreement

You will be held accountable to pay your tuition/co-payment on the payment date, as stated by your payment choice listed below (private or state). Payments are due whether or not your child is in attendance that day, and there will be no refunds for holidays or other regularly scheduled days not spent in our center (more information in Parent Handbook)

We have a STRICT pay ahead schedule

Late payment fees are strictly enforced beginning the day after your payment is due at the rate of \$5.00 per day. Childcare will be temporarily suspended if you are more than three days overdue; and a returned check will result in a \$35.00 charge. After two occurrences, we will only accept cash or money orders.

Annual Registration is due upon enrollment, and every January 1st thereafter.

Private Pay Clients

Registration Fee in the amount of \$_____

Was paid on_____

Monthly Rate \$_____

by method of _____

Transportation Fee \$_____

State Pay Clients

We require approval from your DSHS worker BEFORE your child's first day, and your copayment is due at this time. We must receive verbal notification from your caseworker before your child may return after their termination date, or you will be responsible for payment.

You, the client, are responsible for renewing your contract with the state BEFORE your current contract expires.

The State DOES NOT pay for the transportation fee.

Monthly Rate \$_____

Transportation Fee \$_____

Agreements

Should these amounts change, the client is responsible for that new amount, and should fill out a new Financial Agreement. All unpaid accounts, including a two week notice will be taken to small claims court or will be turned to a collection agency. You, the client, will be responsible for any court fees Lil Hawks incurs.

By signing below, you commit to having read the Parent handbook, and understand all policies and procedures within it. You understand that you are responsible for payment of tuition, registration fees, and and deposit. You further understand that if you fail to give notice before withdrawing your child, you will be held liable for payment of those two weeks tuition.

Parent Signature

Date

GUIDANCE POLICY

Behavior management and discipline is based on the individual child's needs and stage of development. Positive reinforcement and redirection are used to encourage appropriate behavior. Staff will be fair, reasonable, and consistent with their expectations and guidance techniques. If discipline action is needed, our policy states:

- The child will first be given a warning and explanation that their behavior is inappropriate, why, and what acceptable choices they do have.
- If the behavior continues, child will be removed from the activity for a period of one minute per age of the child.
- In cases where the child is causing physical danger to themselves, others, or the environment, they will be taken to the director until the child is ready to rejoin the group. In the most severe case, we will call parents to come and take the child home for a time determined to by the director.
- If behavior continues to be a problem, the child will be suspended for a period to be determined by the director. An incident report will be written and provided to parents at this time.
- If the behavior continues after suspension, the Director will decide if childcare needs to be terminated.

BITING POLICY

First and foremost, our biting policy is implemented for the safety of all children. When children bite, they put others at risk of contracting blood borne diseases. Our staff is trained to work with children who have trouble with biting, and staff will always use universal precautions when dealing with bodily fluids.

- If a child bites more than three times in one day, they will be sent home.
- If a child's bite results in broken skin or draws blood, the child will be sent home immediately.
- At this point, the Director will observe the class to see if there is a determining factor for the biting. The director will work with the teacher to try to discover alternative activities for the child that do not interfere with the class schedule.
- If the Director finds that the teacher is using developmentally appropriate methods and practices, and we have tried all other possible methods, we will need to terminate childcare.

↓ IMPORTANT ↓

Washington state law states:

"Any form of corporal punishment by any person (parent, staff, etc.) on the premises of a childcare facility is illegal. "

Physical restraint is only used as a last resort, if it is needed, for the safety of both the child, and/or their peers; the entire incident will be fully documented, and a copy of the report will be given to the parent, Child Protective Services, and our Licensor.

Photograph and Video Use

Please Choose One

I give permission for my child to appear in photos and videos used for classrooms, literature, ads, displays, panels, books, trainings, etc. I understand that there is no compensation for my child's appearance, and that my child's appearance gives me no ownership rights to the photographs, videos, etc. whatsoever.

Parent Signature

Date

OR

My child MAY NOT be included in photographs or videos from Lil Hawks

Parent Signature

Date

PG Movie Permission

Many classes choose to watch movies for Fun Friday! In order for your children to watch movies at daycare, they have to have a G rating. However, there are many kid friendly movies that have a PG rating (Trolls Minions). Please understand that by signing this, you are giving permission for your child to watch PG movies that are age appropriate at daycare. If you have any questions regarding this, please feel free to ask.

Parent Signature

Date

NON-DISCRIMINATION POLICY

Lil' Hawks is proudly an Equal Opportunity Provider

We do not simply accept difference- we welcome it, celebrate it, support it, and thrive on it for the benefit of everyone. Lil' Hawks does not discriminate against those receiving public assistance; and all children are welcome and accepted regardless of race, creed, color, sex, gender identity, sexual orientation, nationality, political beliefs, or religion. Children with physical disabilities are welcome if our building can sufficiently meet their needs.

Parent Agreement

I acknowledge that I have received a copy of the Parent Handbook, which describes important information about Lil' Hawks. I understand that I should contact Melissa Wells regarding any questions not answered within the handbook.

Since the information and policies described here are subject to change, I acknowledge that revisions to the handbook may occur. All such changes will be communicated through official notices or newsletters, and I understand that revised information may supersede, modify, or eliminate existing policies. Only Melissa Wells, Owner and Director of Lilt Hawks can adopt any revisions to the policies in this handbook. I understand that it is my responsibility to comply with the policies contained in this handbook and any revisions made to it, whether I am a state or private paying client.

I have entered into my childcare relationship with Lil Hawks voluntarily and acknowledge that there is no specific length of childcare services. Accordingly, Lil Hawks or I may terminate this relationship at will, with or without cause, at any time. In accordance with Lil' Hawks policies and procedures, I will give a two-week notice upon deciding to terminate, and if I fail to give proper notice, I will still be held liable for two weeks payment. Lil' Hawks will take all financial matters to small claims court, turn accounts into collection agencies, or take any other action necessary to obtain money owed to them- and any fees accumulate on behalf of this matter will be added to the amount I owe.

I understand that Lil Hawks has established policies to respond appropriately to health care needs, crisis' and/or any disaster that may occur. These policies are posted on the parent bulletin board for me to read at any time. The HealthCare Plan also outlines our policies for compliance with licensing requirements of chapter 17.21 RCW on postings and notification requirements. I may request a copy from the director, if desired. I acknowledge that I have been fully oriented to these guidelines and received information regarding Lil' Hawks Health Care Plan and Crisis/Disaster Response guidelines.

Child's Name

Parent Signature	Date
Social Security Number	

Parent Signature	Date
Social Security Number	

Lil Hawks Representative

Date

Lil Hawks Transportation Permission

COPY TO BE KEPT IN VAN

Child's Name:

First

Last

Middle

Please list any allergies or conditions that could pose an issue while being transported by Lil Hawk's staff

Primary Contact Information

Parent/Guardian Name:	Parent/Guardian Name:
Primary Phone Number:	Primary Phone Number:
Place of Employment:	Place of Employment:
Work Phone #:	Work Phone #:

Alternative Emergency Contact

Name:	Name:
Relationship to Child:	Relationship to Child:
Primary Phone Number:	Primary Phone Number:

Before and After School Care Van Rules

You MUST arrive by 7:55 (8:55 on late start days) for us to transport your children.

Children under 60 lbs. will be in a booster seat; and must remain seated, facing forward, and in their seat belt at ALL TIMES

Children are no longer in our care once they have been dropped off at their school. Upon pick-up, children are not officially in our care until they are INSIDE the Lil Hawks vehicle for transportation back to the center.

Children must respect other people and their property. This includes the van; no ripping, tearing, writing, or any open food or drink.

Parent Responsibilities

You MUST notify us no later than 2:15 p.m. if we do not need to pick up your child/ren. If you fail to notify us, and we went to that school for your child/ren only, you will be charged a \$20.00 fee.

If the child does not make it to the designated pick-up spot within 5 minutes of the bell ringing, the parent will either need to pick the child up from their school, or pay an additional \$20.00 for the driver to go back and pick up the child.

Should a child or parent choose to not follow the above rules, suspension or complete expulsion from before and after school transportation program may occur. Please see Parent Handbook for more information.

I, _____, give permission for my child, _____ to be transported by Lil Hawks for the purpose of school attendance, pre-arranged field trips, in the event of emergencies, or when the need arises I understand that the children will only be transported by a licensed and insured driver with CPR and First Aid Certification, and that a licensing approved first aid kit will be on the van. I know that more information is available regarding transportation is included in the Parent Handbook, and I have discussed these rules with my child.

Parent Signature

Date

Enrollment Survey

You, as a parent, are the expert of your child. The best way for teachers to provide an enriching environment for your child is by getting to know them! Please fill out the following form so that we can use the most appropriate methods when caring for your child. This information is given directly to your child's teacher.

Your home and Your Family

1 Guardian Name/Relationship: _____

Guardian Name/Relationship: _____

2 I prefer my child to be called (nickname): _____

3 Tell us about your household, Who lives with the child?

4 Does your child have any siblings? Please list names and ages if applicable:

5 Does your family have any pets?

6 Are any languages other than English spoken in your home?

Your Child

7 What do you consider to be your child's strengths?

8 Please list any allergies (if applicable)

Enrollment Survey (cont.)

9 Does your child have any special needs?

10 Has your child been in childcare before? If so, what was his/her experience like?

11 What makes your child happy? (Favorite activity, character, game, toy, etc.)

12 Does your child have any behavior problems we should know about?

13 What discipline methods work for your family at home?

14 What discipline methods DO NOT work for your child?

15 What is your biggest goal for your child this year? What do you hope for them to gain?

16 Is there anything else you want us to know about your family or your child?

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:

Insert URL Here

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of Household Member: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Child's First Name	MI	Child's Last Name

Foster Child	Migrant	Runaway	Homeless	Head Start
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income

How often? Weekly Bi-Weekly Monthly Bi-Monthly

B. All Adult Household Members (Including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and last)	Earnings from Work	How often?				Welfare/Child Support/Alimony	Pensions/Retirement/Social Security/SSI/VA Benefits	How often?			
		Weekly	Bi-Weekly	Monthly	2x Month			Weekly	Bi-Weekly	Monthly	2x Month
<input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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Total Household Members (Children and Adults) Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member Check if no SSN

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

<input type="text"/>	<input type="text"/>	<input type="text"/>
Print Name of Adult Signing the Form	Signature of Adult	Today's Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	City	State Zip
<input type="text"/>	<input type="text"/>	Phone/Email

Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	<ul style="list-style-type: none"> A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	<ul style="list-style-type: none"> A child is blind or disabled and receives Social Security benefits A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	<ul style="list-style-type: none"> A friend or extended family member regularly gives a child spending money
Income from any other source	<ul style="list-style-type: none"> A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	Public Assistance/Alimony/Child Support	Pensions/Retirement/All other sources of income
<ul style="list-style-type: none"> Salary, wages, cash bonuses Net income from self-employment (farm or business) <p>If you are in the U.S. Military:</p> <ul style="list-style-type: none"> Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) Allowances for off-base housing, food, and clothing 	<ul style="list-style-type: none"> Unemployment benefits Workers compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits 	<ul style="list-style-type: none"> Social Security (including railroad retirement and black lung benefits) Private Pensions or disability benefits Income from trusts or estates Annuities Investment income Earned interest Rental income Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): Hispanic or Latino Not Hispanic or Latino

Race (check one or more): American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

DO NOT FILL OUT For official use only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income	How often?	Household size	Categorial Eligibility <input type="checkbox"/>	Eligibility																	
<input type="text"/>	<table border="1"> <tr> <td>Weekly</td> <td>Bi-Weekly</td> <td>Monthly</td> <td>2x Month</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	Weekly	Bi-Weekly	Monthly	2x Month	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="checkbox"/>	<table border="1"> <tr> <td>Free</td> <td>Reduced</td> <td>Denied</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	Free	Reduced	Denied	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Weekly	Bi-Weekly	Monthly	2x Month																		
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																		
Free	Reduced	Denied																			
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																			
Determining Official's Signature	Date	Confirming Official's Signature	Date	Follow-up Official's Signature	Date																



Certificate of Immunization Status (CIS)

Reviewed by: _____ Date: _____
 Signed COE on File? Yes No

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

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):
I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.		Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.	
X _____ Parent/Guardian Signature Date		X _____ Parent/Guardian Signature Required if Starting in Conditional Status Date	

▲ Required for School • Required Child Care/Preschool	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Required Vaccines for School or Child Care Entry						
●▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)						
●▲ DT or Td (Tetanus, Diphtheria)						
●▲ Hepatitis B						
● Hib (<i>Haemophilus influenzae type b</i>)						
●▲ IPV (Polio) (any combination of IPV/OPV)						
●▲ OPV (Polio)						
●▲ MMR (Measles, Mumps, Rubella)						
● PCV/PPSV (Pneumococcal)						
●▲ Varicella (Chickenpox) <input type="checkbox"/> History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
COVID-19						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

Documentation of Disease Immunity (Health care provider use only)

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:

A verified history of varicella (chickenpox) disease.

Laboratory evidence of immunity (titer) to disease(s) marked below.

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

Polio (all 3 serotypes must show immunity)

▶ _____

Licensed Health Care Provider Signature Date

▶ _____

Printed Name

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

Health Care Provider or School Official Name: _____ Signature: _____ Date: _____

If verified by school or child care staff the medical immunization records must be attached to this document.

Instructions for completing the Certificate of Immunization Status (CIS): Print the from the Immunization Information System (IIS) or fill it in by hand.

To print with the immunization information filled in:

Ask if your health care provider's office enters immunizations into the WA Immunization Information System (Washington's statewide registry). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at <https://wa.myir.net>. If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waisrecords@doh.wa.gov or 1-866-397-0337.

To fill out the form by hand:

1. Print your child's name and birthdate, and sign your name where indicated on page one.
2. Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides 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.
3. If your child had chickenpox (varicella) disease and not the vaccine, a health care provider must verify chickenpox disease to meet school requirements.
 - If your health care provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
 - If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.
4. If your child can show positive immunity by blood test (titer), have your health care provider check the boxes for the appropriate disease in the Documentation of Disease Immunity section, and sign and date the form. You must provide lab reports with this CIS.
5. Provide proof of medically verified records, following the guidelines below.

Acceptable Medical Records

All vaccination records must be medically verified. Examples include:

- A Certificate of Immunization Status (CIS) form printed with the vaccination dates from the Washington State Immunization Information System (IIS), MyIR, or another state's IIS.
- A completed hardcopy CIS with a health care provider validation signature.
- A completed hardcopy CIS with attached vaccination records printed from a health care provider's electronic health record with a health care provider signature or stamp. The school administrator, nurse, or designee must verify the dates on the CIS have been accurately transcribed and provide a signature on the form.

Conditional Status

Children can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. (Vaccine series doses are spread out among minimum intervals, so some children may have to wait a period of time before finishing their vaccinations. This means they may enter school while waiting for their next required vaccine dose). To enter school or child care in conditional status, a child must have all the vaccine doses they are eligible to receive before starting school or child care.

Students in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to turn in documentation of vaccination. If a student is catching up on multiple vaccines, conditional status continues in a similar manner until all of the required vaccines are complete.

If the 30-day conditional period expires and documentation has not been given to the school or child care, then the student must be excluded from further attendance, per RCW 28A.210.120. Valid documentation includes evidence of immunity to the disease in question, medical records showing vaccination, or a completed certificate of exemption (COE) form.

Reference guide for vaccine trade names in alphabetical order

For updated list, visit <https://www.cdc.gov/vaccines/terms/usvaccines.html>

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Fluarix	Flu	Havrix	Hep A	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)
Adacel	Tdap	Flucelvax	Flu	Hiberix	Hib	Pediarix	DTaP + Hep B + IPV	RotaTeq	Rotavirus (PV5)
Afluria	Flu	FluLaval	Flu	HibTITER	Hib	PedvaxHIB	Hib	Tenivac	Td
Bexsero	MenB	FluMist	Flu	Ipov	IPV	Pentacel	DTaP + Hib +IPV	Trumenba	MenB
Boostrix	Tdap	Fluvirin	Flu	Infanrix	DTaP	Pneumovax	PPSV	Twinrix	Hep A + Hep B
Cervarix	2vHPV	Fluzone	Flu	Kinrix	DTaP + IPV	Prevnar	PCV	Vaqta	Hep A
Daptacel	DTaP	Gardasil	4vHPV	Menactra	MCV or MCV4	ProQuad	MMR + Varicella	Varivax	Varicella
Engerix-B	Hep B	Gardasil 9	9vHPV	Menomune	MPSV4	Recombivax HB	Hep B		