Office Use	
Year	
Deposit	
Ist Month	
Immune	
Background	

Charter Oak Cooperative Preschool Registration

Child's Full Name _____ D.O.B _____ Gender _____

Address _____

Name of Parent/Guardian _____

Address _____

Phone _____ Work _____

Email _____

Who has legal responsibility for this child? _____

Main language spoken at home _____

Any other relevant information _____

Allergies/medical conditions _____

Emergency Contacts - Must be different from above

#1 Name _____ Relationship _____ Phone_____

#2 Name _____ Relationship _____ Phone _____

In the event of an accident or sudden illness and parents cannot be immediately contacted, I hereby authorize Charter Oak Cooperative Preschool Staff to obtain any needed medical and/or hospital treatment care for my child. I will assume any expenses incurred for said emergency care.

Parent/Guardian _____ Valid from __/__/__ to __/__/___

Preferred Doctors/Hospital _____ Phone _____

We take photographs of the children for use on our website, printed publicity or class yearbook with your permission.

I give Charter Oak Community Church consent to use images of my child for the **purpose of preschool promotion and school yearbook.** _____

I give Charter Oak Community Church consent to use images of my child for the purpose of **preschool yearbook only.** _____

Who, other than you, is authorized to pick your child up from preschool? (ID will be requested)

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

General Information

What are the names and ages of your child's siblings? _____

_____

Who are the other people living in the home? _____

_____

Is there anything special you would like us to know about your child? _____

_____

What are your child's favorite toys/activities? _____

_____

Has your child participated in group activities before? _____

_____

Does your child have any toileting difficulties? _____

_____

_____ I have read and understand the Charter Oak Cooperative Preschool Handbook and agree to adhere to all the requirements stated while my child is enrolled in the program.

Financial Agreement

_____ I agree to pay the annual $35.00 non-refundable registration fee (per family) along with $80.00 for first month tuition at time of registration.

____ I understand that monthly tuition payments are due by the 5th of each month beginning in September through April.

____ I choose to pay the annual tuition amount of $ 720,00 minus a discount of $ 36.00 at registration. I understand that I will be reimbursed for prepaid tuition based on full annual tuition cost and contingent on 30-day written notice to the school if I need to remove my child from the program before the school year is complete.

____ I understand that I will be responsible for fulfilling 3 classroom workdays each month as a parent helper for every child I have enrolled.

Signed _____ Date _____

Completed registration packet and fees must be submitted to compete enrollment and reserve you space.

Please return to:

Charter Oak Community Church
PO Box 730
Battle Ground, WA 98604

Certificate of Immunization Status (CIS)

Washington State Department of Health

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	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date 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 (*Haemophilus influenzae type b*)						
•▲ IPV (Polio) (any combination of IPV/OPV)						
•▲ OPV (Polio)						
•▲ MMR (Measles, Mumps, Rubella)						
• PCV/PPSV (Pneumococcal)						
•▲ Varicella (Chickenpox) ☐ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
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.

☐ Diphtheria	☐ Hepatitis A	☐ Hepatitis B
☐ Hib	☐ Measles	☐ Mumps
☐ Rubella	☐ Tetanus	☐ 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: waiisrecords@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 Pediatix 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	Ipol	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		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633, Olympia WA 98504-2633

REQUEST FOR CRIMINAL HISTORY INFORMATION
CHILD/ADULT ABUSE INFORMATION ACT
RCW 43.43.830 THROUGH 43.43.845

A **REQUESTING AGENCY/ADDRESS**

Charter Oak Community Church
Agency

Attn

PO Box 730
Address

Battle Ground, WA 98604
City/State/Zip

I certify this request is made pursuant to and for the purpose indicated.

[signature] 1-9-18
Authorized Signature Date

Lead Pastor 360-607-2080
Title Area Code/Phone Number

B **PURPOSE**
Check appropriate box

- [ ] Educational School District (ESD)/School District Volunteer – no fee
- [X] Non-Profit Business/Organization – no fee (Excluding Schools & ESD's)
- [ ] Profit Business/Organization - $17
- [ ] Adoptive Parent - $17
- [ ] Receive background results electronically

Email address _____

Password _____ (must be at least 8 characters)

Fees: Make payable to Washington State Patrol by check, money order, or business account.

Notary letters certifying the results are available upon request. There is an additional $10.00 processing fee per notary seal.

_____ **Notarized Letter(s)**

C **APPLICANT OF INQUIRY** (Please provide as much information as possible; name and date of birth are mandatory.)

Applicant's Name: _____
Last First Middle

Alias/Maiden Name(s): _____

Date of Birth: _____ Sex: _____ Race: _____
Month/Day/Year

Secondary dissemination of this criminal history record information response is prohibited unless in compliance with statute.

D **WASHINGTON STATE PATROL IDENTIFICATION & CRIMINAL HISTORY SECTION**

As of this date, the applicant named below has no record pursuant to RCW 43.43.830 through 43.43.845.

_____
Requesting Agency

_____
Applicant's Signature

_____
Applicant's Name

_____
Address

_____
City/State/Zip

3000-240-430 (R 6/12)