



**Community Day School  
Association**

*Discovering and Cultivating the Best in Each Child*

**School Age  
Enrollment Packet  
2010-2011  
School Year**



**Community Day School Association**

**Enrollment Application  
2010-2011**

Center Name: \_\_\_\_\_

**CHILD INFORMATION**

\_\_\_\_\_ New Student \_\_\_\_\_ Returning Student

Child: First \_\_\_\_\_ Last \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_  
School and Room # \_\_\_\_\_ Teacher \_\_\_\_\_ Bus # \_\_\_\_\_ Pick up/Drop  
off location \_\_\_\_\_ a.m. pick up time \_\_\_\_\_ p.m. pick up time \_\_\_\_\_ **Requested start date** \_\_\_\_\_

**PAREN/GUARDIAN INFORMATION**

1. Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ E-mail \_\_\_\_\_

\*Please check here if you agree to receiving your monthly invoice by email at the address given above

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

2. Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ E-mail \_\_\_\_\_

\* Please check here is you agree to receive your monthly invoice by email at the address given above

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

Family Living Together / Apart (*please circle*) Child's Main Residence \_\_\_\_\_

Sibling(s) and their age(s) \_\_\_\_\_

**Emergency Contacts**

First \_\_\_\_\_ Last \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

First \_\_\_\_\_ Last \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

First \_\_\_\_\_ Last \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

In case of emergency and I cannot be contacted, I hereby give permission for my child to be given emergency treatment by a qualified staff member at Community Day School Association, to be transported by ambulance or aid car to an emergency center, and/or to receive whatever medical, surgical, and hospital care, treatment, and procedures are deemed immediately necessary by the attending physician to safeguard my child's health.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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**Out of Area Contact** (i.e. natural disaster)

First \_\_\_\_\_ Last \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

**AUTHORIZED ESCORTS** (Person's authorized to pick up your child from CDSA)

1. Name \_\_\_\_\_ Last \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

2. Name \_\_\_\_\_ Last \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

3. Name \_\_\_\_\_ Last \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

Is there anyone CDSA should be aware of who has a legal restraining order prohibiting or limiting contact with your child? **YES NO** (please circle) **If YES, please list his/her name and attach the required legal document to this form.**

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Any custody or visiting arrangements CDSA needs to be aware of? \_\_\_\_\_

\_\_\_\_\_

<p><b>How did you hear about CDSA?</b></p> <p>_____ Flier mailed to my home</p> <p>_____ Flier came home with my child, from Seattle Public Schools</p> <p>_____ Roadside Banner or Lawn Sign</p> <p>_____ Internet/Web Site</p> <p>_____ CDSA Employee _____</p> <p>_____ CDSA Parent _____</p> <p>_____ Other _____</p>
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**EMERGENCY/HEALTH INFORMATION FORM**

Physician: Name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Dentist: Name: \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Name of Insurance Policy \_\_\_\_\_ Policy# \_\_\_\_\_

Food or Drug Allergies \_\_\_\_\_

What additional information should CDSA be aware of if your child comes in contact with the allergen? \_\_\_\_\_

Date of last complete health exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last Tetanus shot \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last Dental exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Please describe any specific health or emotional problems (*vision, hearing loss, diabetes, etc.*) or pertinent family background information which CDSA should be aware of (*use back if necessary*)

\_\_\_\_\_  
\_\_\_\_\_

Community Day School Association (CDSA) requires all medications taken by the child to be listed below:

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**Please indicate below if your child has any of the following medical conditions:**

- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Eczema
- \_\_\_\_\_ Epilepsy
- \_\_\_\_\_ Fainting Spells
- \_\_\_\_\_ Frequent colds
- \_\_\_\_\_ Frequent ear infections
- \_\_\_\_\_ Frequent sore throats
- \_\_\_\_\_ Frequent nosebleeds
- \_\_\_\_\_ Heart concerns
- \_\_\_\_\_ Problems with diarrhea
- \_\_\_\_\_ Problems with constipation



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\_\_\_\_\_ Stomach upsets  
\_\_\_\_\_ Urinary problems  
\_\_\_\_\_ Other \_\_\_\_\_

**EMOTIONALLY SAFE AND HEALTHY LEARNING ENVIRONMENT**

Community Day School strives to ensure that our children are emotionally and physically healthy. To ensure a healthy and safe environment, we request that you provide us with any information regarding any current or previous behavior challenges that your child may have had or has. Based on the professional levels of our employees, we will provide the best possible care for your child.

1. Does your child have disabilities or any health concerns that will affect his or her ability to participate in activities?  
If yes, please explain.
  
2. Has your child ever been suspended from school? \_\_\_\_\_ No \_\_\_\_\_ Yes    Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
If yes, please explain.
  
3. Is or has your child ever been on an Individual Education Plan (IEP)? \_\_\_\_\_ No \_\_\_\_\_ Yes  
If yes, please explain (please include specific dates of initial IEP and/or upcoming reviews, etc)

I hereby certify that all the information is true and accurate.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Family Biographical Information Form**

The staff members of Community Day School Association are dedicated to insuring that your child’s needs are served to the fullest of our abilities. We feel that it is important that we have as much information about your child as possible to enable us to meet this goal.



## Community Day School Association

Please help us get to know your child, as well as your needs and expectations from our program by completing the following questionnaire. Thank you.

Parent's Name      First \_\_\_\_\_      Last \_\_\_\_\_

Child's Name      First \_\_\_\_\_      Last \_\_\_\_\_

1. Does your child have a nick name he/she prefers?
2. Please describe some of your child's favorite activities.
3. Please describe some activities that your child does not enjoy.
4. What are your child's favorite foods? Least favorites?
5. When your child is angry or upset, what kind of behaviors are they likely to exhibit?
6. At CDSA we are pleased to have many different types of families represented in our program population. Please describe your family to us, (i.e. ethnic background, family living situation, siblings and relatives in the household, etc.)
7. Have there been recent family changes?
8. What activities would you like to see your child doing at CDSA?
9. What expectations do you have of the program?
10. CDSA is dedicated to offering programs that are of interest and benefit to parents and families as well as to children. Please rate the following topics in order of their importance and relevance to you.

\_\_\_\_\_ Parenting Skills

\_\_\_\_\_ Anger and Stress Management



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\_\_\_\_\_ Self-Esteem

\_\_\_\_\_ Conflict Resolution

\_\_\_\_\_ Adolescence and Growing up issues

\_\_\_\_\_ Other

11. Is your family in need of resources? \_\_\_\_\_ No \_\_\_\_\_ Yes (check all that apply)

\_\_\_\_\_ Clothing

\_\_\_\_\_ Counseling

\_\_\_\_\_ Food

\_\_\_\_\_ Health/Medical

\_\_\_\_\_ Lodging/Shelter

\_\_\_\_\_ Other

12. CDSA invites you and your family to get involved in our program. Please share ways in which you are willing and able to become involved:

\_\_\_\_\_ Classroom/Fieldtrips

\_\_\_\_\_ Donations

\_\_\_\_\_ Tutoring

\_\_\_\_\_ Volunteering

\_\_\_\_\_ Administrative

\_\_\_\_\_ Events



**Community Day School Association  
2010 - 2011 School Age Tuition Agreement**

Parent's Name \_\_\_\_\_

Child's Name \_\_\_\_\_ Center \_\_\_\_\_

*Please initial each agreement and sign at the bottom.*

<u>Initial</u>						
_____	1. An annual registration fee of \$50 <u>per child</u> is payable <u>at the time of registration</u> and is non-refundable.					
_____	Paid	_____	Included			
_____	2. My base tuition is \$_____ per month, <u>payable IN ADVANCE</u> . <b>School-age tuition</b> is based on a 12 month school year including summer camp and <b>100% tuition will be charged September through June</b> . Winter Break, Mid-Winter Break and Spring Break months are <b>NOT</b> discounted. June may or may not be discounted depending on when the school year ends. 10% sibling discount applies to <u>base tuition only</u> .					
_____	3. <i>(For subsidized families)</i> My copayment amount is determined by the organization and is subject to change. I understand that I am responsible for payment of care not covered by the funding source and my copayment for care is payable in advance. My funding organization is (circle one) DSHS City of Seattle					
_____	4. <i>(For subsidized families)</i> <b>Written proof of coverage is required before care can begin. If proof cannot be obtained prior to enrollment, you must pay in advance for your child's care.</b> You must be allocated full-time hours from your subsidy organization to get full time care during school breaks, in-service days, other school closures and summer camp. If you are only allocated half-time care your child may only attend for half a day. <b>For city subsidy families</b> , additional fees will be charged for full day care during school breaks, and may be charged for in-service days, and other school closures.					
_____	5. <i>(For subsidized families)</i> DSHS - Absences may not exceed five (5) per month. City - Absences may not exceed ten (10) per month. Children with excessive absences will be asked to leave the program.					
_____	6. My child will attend CDSA ( <i>circle days of the week</i> ): 5 days or 3 days ONLY					
	Before School Only	MON	TUE	WED	THU	FRI
	After School Only	MON	TUE	WED	THU	FRI
	Before and After	MON	TUE	WED	THU	FRI
	Summer Camp (five days only)	MON	TUE	WED	THU	FRI
_____	7. CDSA provides optional care on in-service days, early dismissal, and other school closure days. Optional care may not part of your regular tuition and is provided at an additional fee to be paid in advance of the care. Drop in care is also available at an additional fee. <i>(See page 13 of the Family Information Guide for details)</i>					
_____	8. Refunds are not given for sick days, snow days, natural disasters or other unscheduled absences.					
_____	9. I agree that should I need to make a schedule change or cancel childcare needs that I submit a <b>Schedule Change Form no later than the 20<sup>th</sup> of the month preceding the change</b> and I agree that tuition will not be refunded within the month following the date notification of a change was made.					
_____	10. Child(ren) must be picked up by 6 p.m. Beginning at 6:01 p.m., a \$5.00 late charge will be assessed for the first five minutes and then a \$1.00 for every minute thereafter payable to CDSA the same day.					

Signature \_\_\_\_\_ Date \_\_\_\_\_



**Community Day School Association  
2010-2011 School Age Parent Agreement**

Parent's Name \_\_\_\_\_

Child's Name \_\_\_\_\_ Center \_\_\_\_\_

*Please initial each agreement and sign at the bottom. Return original to the Center Director with the emergency form, tuition agreement, immunization form, biographical information form, food program form, and United Way client demographic form..*

<u>Initial</u>	<p>_____ 1. I grant permission for CDSA to provide care to my child including use of play equipment and supplies, involvement in all activities and participation in fieldtrips.</p> <p>_____ 2. I have provided CDSA with the following information on the emergency form:</p> <p>_____ <b>Parent/Guardian name, address, home, cell and work phone numbers</b></p> <p>_____ <b>Emergency contacts</b></p> <p>_____ <b>Physician name and phone number</b></p> <p>_____ <b>Food or drug allergies, asthma, disabilities, any chronic medical need, etc.</b></p> <p>_____ <b>Persons authorized to pick up your child from CDSA plus phone numbers</b></p> <p>_____ <b>Any additional relevant information</b></p> <p>_____ 3. I understand that CDSA is not responsible for personal items brought from home that may be lost.</p> <p>_____ 4. I give permission for my child to be included in photographs taken at CDSA. I understand that photographs of my child may be used in our publications, including our website and marketing materials. I am able to withdraw my permission at any time for my child's photograph to be used in CDSA publications and will notify my Center Director in writing.</p> <p>_____ 5. I have read and understand the Family Information Guide and am aware that CDSA reserves the right to decline enrollment for any of the following reasons:</p> <p>a. CDSA Conflict-Resolution Policy (<i>See page 19 of the Family Information Guide for details</i>)</p> <p>b. Non-payment of tuition/co-payment by due date</p> <p>c. Non-payment of tuition because subsidy has been denied or expired</p> <p>d. Physical or emotional problems that are beyond reasonable accommodations</p> <p>e. Parent/Guardian failure to comply with CDSA's policies and procedures</p> <p>_____ 6. I have included on the emergency form all information that could significantly affect my child's ability to work with staff and other children. I will notify CDSA of any address and phone number changes.</p> <p>_____ 7. CDSA is not responsible for anything that may happen as a result of incomplete information given by a parent/guardian on the emergency form or other documentation at the time of enrollment.</p> <p>_____ 8. Children with the mental &amp; physical capacity to apply sun screen will self apply under the supervision of CDSA staff. If the child is unable to do so, a CDSA staff member will apply as needed.</p> <p>_____ 9. I agree to send a nutritionally balanced lunch with my child (ren) daily during full days and breaks. <i>CDSA is required by law to monitor the nutritional content of food that is consumed during meals and snacks while in our care.</i></p> <p>_____ 10. I understand that I have access to view the center's Disaster Plan, Pesticide and Health Care Policy.</p> <p>_____ 11. I give permission for my child to participate in walking field trip in the neighborhood. I understand that will occur without written permission.</p> <p>Signature: _____ Date: _____</p>
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## Child and Adult Care Food Program ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 - CHILDREN'S INFORMATION												
Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care				Circle Meals Normally Received					
			Sun	Mon	Tu	Wed	Th	Fri	Sat	Breakfast	A.M. Snack	Lunch
			Normal Hours _____ to _____				P.M. Snack	Supper	Eve. Snack			
			Sun	Mon	Tu	Wed	Th	Fri	Sat	Breakfast	A.M. Snack	Lunch
			Normal Hours _____ to _____				P.M. Snack	Supper	Eve. Snack			
			Sun	Mon	Tu	Wed	Th	Fri	Sat	Breakfast	A.M. Snack	Lunch
			Normal Hours _____ to _____				P.M. Snack	Supper	Eve. Snack			

### INCOME ELIGIBILITY

Please check one box:

- My child(ren) receive(s) benefits from Washington Basic Food (WBF), TANF, or FDPIR. (Please complete Part 2 and 5.)
- This child is a foster child. (Please complete Part 3 and 5.) One form per foster child.
- My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)
- My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 - CHILDREN RECEIVING WASHINGTON BASIC FOOD (WBF), TANF, OR FDPIR				
Child's Name	Circle One			Case Number or Identification Number
	WBF	TANF	FDPIR	
	WBF	TANF	FDPIR	
	WBF	TANF	FDPIR	

PART 3 - FOSTER CHILD—One form per foster child	
Child's Name	Child's Personal Use Monthly Income (if None, Write "0")

PART 4 - TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not Required if You Have Reported a Case Number in Part 2				
List Names (First and Last) of Everyone in Your Household	Gross Income from Last Month (if None, Write "0")			
	Earnings from Work Before Deductions	Alimony, Child Support, etc.	Retirement, Pensions, Soc. Sec., etc.	Job Two or Any Other Income
1.				
2.				
3.				
4.				
5.				
6.				
7.				

PART 5 - SIGNATURE AND CERTIFICATION			
<p>The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list his/her Social Security Number or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) If you have listed a case number in Part 2 or are applying for a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, a Social Security number is not needed.</p> <p>I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.</p>			
Signature of Adult	Date	Print Name of Adult Signing	<input type="checkbox"/> I do not have a Social Security Number
		Social Security Number	
ADDRESS	CITY/STATE/ZIP CODE	DAYTIME PHONE	

**PART 6 – IDENTIFYING INFORMATION AND CERTIFICATION OF DATA—You Are Not Required to Answer This Part.**

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

**Ethnicity:**

- Hispanic or Latino
- Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, gender, age, or disability.

**Race:**

- White
- Black or African American
- Asian
- American Indian or Alaskan Native
- Native Hawaiian or Pacific Islander
- Multi-Racial

If you feel you have been discriminated against, you should write the Secretary of Agriculture, Washington, DC 20250.

**PRIVACY ACT STATEMENT**

Section 9 of the National School Lunch Act requires that, unless the participant's WBF, TANF, or FDPIR case number is provided, you must include the social security number of the adult household member signing the application, or indicate that the household member does not have a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the signer does not have a social security number, the application cannot be approved. This notice must be brought to the attention of the household member whose social security number is disclosed. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a WBF or welfare office to determine current certification for receipt of WBF or TANF benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims; or legal actions if incorrect information is reported.

**CENTER USE ONLY**

- Check one:  Free Category  
 Reduced-Price Category  
 Above-Scale Category

MONTHLY INCOME CONVERSION  
WEEKLY X 4.33    EVERY 2 WEEKS X 2.15    TWICE A MONTH X 2

Total Monthly Income \$ \_\_\_\_\_

This form must be signed and dated by the institution's authorized representative.

\_\_\_\_\_  
SIGNATURE OF INSTITUTION'S AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE

## 2009 - 2010 HUD Income Categories

Instructions: Find the column for the number of people in your household. Go down that column until you find the income range for your annual gross income last year. Look to the left to see what that row is labeled. That is your Income category.

Household → ↓ Category	1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8 Persons
<u>Category A.</u> Very Low. 30% HUD PMSA	Up to \$17,700	Up to \$20,250	Up to \$22,750	Up to \$25,300	Up to \$27,300	Up to \$29,350	Up to \$31,350	Up to \$33,400
<u>Category B.</u> Low. 50% HUD PMSA	\$17,701 to \$29,500	\$20,251 to \$33,700	\$22,751 to \$37,950	\$25,301 to \$42,150	\$27,301 to \$45,500	\$29,351 to \$48,900	\$31,351 to \$52,250	\$33,401 to \$55,650
<u>Category C.</u> Moderate. 80% HUD PMSA	\$29,501 to \$44,800	\$33,701 to \$51,200	\$37,951 to \$57,600	\$42,151 to \$64,000	\$45,501 to \$69,100	\$48,901 to \$74,250	\$52,251 to \$79,350	\$55,651 to \$84,500
<u>Category D.</u> Above Moderate. Above 80% HUD PMSA	\$44,801 or More	\$51,201 or More	\$57,601 or More	\$64,001 or More	\$69,101 or More	\$74,251 or More	\$79,351 or More	\$84,501 or More

**Note:**

- FY 2009, Washington State Median 4-Person Family Income = \$84,300
- HUD (U.S. Department of Housing & Urban Development)
- PMSA (Primary Metropolitan Statistical Areas)



Is there an accompanying signed Certificate of Exemption on file?  
 Yes  No

Date: \_\_\_\_\_

Staff Signature \_\_\_\_\_

# Certificate of Immunization Status (CIS)

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Child's Address: \_\_\_\_\_  
 Child's Birthdate: \_\_\_\_\_ Child's Sex: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Day Phone: \_\_\_\_\_

If completing by hand, write the vaccine in the row to the left of "Dose" and the date the vaccine was received in the "Date" column. Age column is optional.  
 ♦ Required for School and Child Care/Preschool • Required for Child Care/Preschool Only

Vaccine	Dose	Date	Age	Vaccine	Dose	Date	Age
♦ Hepatitis B (Hep B)	1			Hepatitis A (Hep A)	1		
	2				2		
	3						
Hepatitis B (Hep B) Alternate schedule for teens	1			Meningococcal (MCV4, MPSV4)	1		
	2						
Rotavirus	1			Human Papillomavirus (HPV)	1		
	2				2		
	3				3		
♦ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)	1			Other			
	2						
	3						
	4						
	5						
♦ Diphtheria, Tetanus, Pertussis (Tdap, Td)	1			I certify that the information provided here is correct and verifiable.			
	2						
• Haemophilus influenzae type b (Hib)	1			Signature of Parent or Guardian _____ Date _____			
	2						
	3						
	4						

See the back of this page for documentation of immunity, a vaccine trade name reference guide, and a vaccine abbreviation list.

Verification of varicella disease history ▼  
 Health Care Provider (HCP) Verified  Signed note from HCP attached or HCP provider signature here: \_\_\_\_\_  
 HCP Verified by Registry  No HCP sig required if box at left checked.  If school staff find verification in the Registry, then school staff must: \_\_\_\_\_  
 Parental Report  ONLY acceptable for some grades. Write date or age child had disease: \_\_\_\_\_

Licensed HCP Signature (MD, DO, ND, PA, ARNP) \_\_\_\_\_ Date \_\_\_\_\_  
 Either initial with parent approval or get parent signature below:  
 Staff initials indicating parent approval: \_\_\_\_\_  
 Parent Signature indicating approval: \_\_\_\_\_

## Documentation of Immunity by Blood Test (titer)

I certify that the child named on this form has laboratory evidence of immunity to (check all that apply):

- Diphtheria     Hepatitis A     Hepatitis B     Hib     Measles     Mumps     Polio     Rubella     Tetanus     Varicella  
 Other (list): \_\_\_\_\_     lab report(s) attached (required)

X

Typed or Printed Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X

Signature of Licensed Health Care Provider (required)

Date (required)

### Vaccine Trade Names\*

Read down and across - Trade Names are in Alphabetical Order.

Trade Name	Vaccine	Trade Name	Vaccine
Acel-Imune	DTaP	Menomune	MPSV4
ActHIB	Hib	OmniHIB	Hib
Adacel	Tdap	Pediarix	DTaP + IPV + Hep B
Boostrix	Tdap	PedvaxHIB	Hib
Certiva	HPV	Pentacel	DTaP + IPV + Hib
Comvax	Hib + Hep B	Pentavalente	DTaP + Hep B + Hib
Daptacel	DTaP	Pneumovax	PPV23
Decavac	Td	Prevnar	PCV or PCV7
Engenix-B	Hep B	ProHIBit	Hib
Fluarix	Flu	ProQuad	MMRV
FluMist	Flu	Quadracel	DTaP + IPV
Fluvirin	Flu	Recombivax	Hep B
Fluzone	Flu	Rotarix	Rotavirus
Gardasil	HPV	RotaTeq	Rotavirus
Havrix	Hep A	Tetramune	DTP + Hib
HibTITER	Hib	TriHIBit	DTaP + Hib
HyperTET	TIG	Tri-Immunol	DTP
HyperHEP B	HBIG	Tripedia	DTaP
Ipol	IPV	Twinrix	Hep B + Hep A
Infanrix	DTaP	Vaqtta	Hep A
Kinrix	DTaP + IPV	Varivax	Varicella
Menactra	MCV4		

### Vaccine Abbreviations\*

Read down - Abbreviations are in Alphabetical Order.

Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus
DTaP	Diphtheria, Tetanus, acellular Pertussis
DTP	Diphtheria, Tetanus, Pertussis
Flu (TIV or LAIV)	Influenza
HBIG	Hepatitis B Immune Globulin
Hep A (HAV)	Hepatitis A
Hep B (HBV)	Hepatitis B
Hib	Haemophilus influenzae type b
HPV	Human Papillomavirus
IPV	Inactivated Poliovirus Vaccine
MCV4	Meningococcal Conjugate Vaccine
MPSV4	Meningococcal Polysaccharide Vaccine
MMR	Measles, Mumps, Rubella
MMRV	Measles, Mumps, Rubella, Varicella
OPV	Oral Poliovirus vaccine
PCV or PCV7	Pneumococcal Conjugate Vaccine
PPV23	Pneumococcal Polysaccharide Vaccine
Rota (RV1 or RV5)	Rotavirus
Td	Tetanus, Diphtheria
Tdap	Tetanus, Diphtheria, acellular Pertussis
TIG	Tetanus immune globulin
VAR or VZV	Varicella

\*These lists may not be comprehensive; visit <http://www.doh.wa.gov/cfh/immunize/forms/default.htm> for updated lists.



## Sunscreen Authorization Form (Program-Provided/Bulk Sunscreen)

Child's Name:	Date of Birth & Age: <small>(Do not apply on infants 6 months &amp; younger without written permission from health care provider)</small>
Start Date:	Stop Date: (up to 6 months after 'start date')
Times to be Applied:	Special Instructions:

I authorize the use of the following "program-provided" sunscreen on my child.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Daytime Phone Number

### Program-Provided Sunscreen *(to be completed by child care provider)*

Name of Sunscreen & SPF:	Active Ingredients:
Possible Side Effects:	Other Label Information:

Reason for medication: Protection from sun  
Amount to be given: Cover exposed areas of skin  
Route: Topical  
Storage: Room temperature



## Standardized Client Demographic Data Collection Form for use 01 July 2010 through 30 June 2011

<b>Agency</b>	Community Day School Association	<b>0000012243</b>
<b>Outcome</b>	Youth/children develop/strengthen skills/competencies/assets that support positive development	<b>02204</b>

**Client Instructions:** Please neatly enter numbers or make an X in the appropriate boxes to answer the questions. Please note your name is not a part of this survey so that your identity is totally confidential.

### I. Geographic Region:

1. What is the Zip Code where you live:

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Homeless – formerly from ZIP and/or City

2. City Name \_\_\_\_\_  
(if not in a city, write in "Unincorporated")

Unknown

### II. Household Composition

1. Number of people living in your household  
(including yourself) 

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Unknown

2. Number of children under 18 

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Unknown

3. If you are in a single parent household, is the head of the household male or female?

Male (1)

Female (2)

Unknown (9)

### III. Household Income Level

1. What is the total gross yearly income for your household, based on King County HUD guidelines?

Under 30% of Median Income (1)

Under 50% of Median Income (2)

Under 80% of Median Income (3)

Equal or Above 80% of Median Income (4)

Unknown (9)

### IV. Living Situation

1. Are you Homeless?

Yes (1)

No (0)

Unknown (9)

If homeless "Yes",

2. How many times have you been homeless in the past three years?

Number of times 

--	--

 Unknown

3. How long have you been homeless this last time?

Number of months 

--	--

 Unknown

### V. Age Group

1. What is your child's age at intake?

Number of Years 

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Age Unknown

### VI. Gender

1. Please check one of the following

Female (1)

Male (2)

Transgendered (3)

Other (4)

Unknown (9)

### VII. Persons with Disabilities

1. Do you consider yourself to be a person with a disability?

Yes (1)

No (0)

Unknown (9)

(Continued on Page 2)

**VIII. Spanish/Hispanic/Latino**

1. Are you Spanish/Hispanic/Latino?  
 Yes (1)  
 No (0)  
 Unknown (9)

**IX. Race**

1. What is your race? (Check all that apply)

- a.**  
 American Indian (U.S. Tribe)  
 Alaska Native, Aleut, Eskimo  
 Indigenous to Americas (Other than U.S.)
- b.**  
 Asian Indian  
 Cambodian  
 Chinese, Except Taiwanese  
 Filipino  
 Japanese  
 Korean  
 Vietnamese  
 Other Asian
- c.**  
 Indigenous African/Black  
 African American/Black  
 Other Black
- d.**  
 Hawaiian Native  
 Polynesian (Samoan, Tongan, Other)  
 Micronesian (Guamanian/Chamorro, Other)  
 Other Pacific Islander
- e.**  
 Arab/Iranian or Middle Eastern  
 Other White/Caucasian
- f.**  
 Other
- G.**  
 Unknown

**X. Refugee/Immigrant**

1. Are you an immigrant or refugee or new arrival to this country?  
 Yes (1)  
 No (0)  
 Unknown (9)

**XI. Limited English Proficiency**

1. Are you limited in your ability to communicate in English?  
 Yes (1)  
 No (0)  
 Unknown (9)

**XII. Employment Status at Intake**

1. Are you currently employed?  
 Yes (1)  
 No (0)  
 Unknown (9)

**XIII. Educational Level Adults (for adults only)**

1. What is the highest grade or degree that you have achieved?
- Less than High School graduate (1)  
 High School diploma or GED (2)  
 Some college—no degree or certificate (3)  
 Certificate from business school or other professional program (4)  
 Associates Degree (5)  
 Bachelors Degree or above (6)  
 Child under 18 (7)  
 Unknown (9)

**XIV. Veterans/Military Status**

1. Have you ever served on active duty in the U.S. military (including National Guard or Reserves)  
 Yes (1)  
 No (0)  
 Unknown (9)

*Thank you for your cooperation. Individual responses will be kept completely confidential at all times*



United Way of King County