

Northshore School District #417
NORTHSHORE MIDDLE SCHOOL (NMS)
12101 NE 160th Street, Bothell, WA 98011
Ph: (425) 408-6718 | Fax: (425) 408-6702
NMS Registrar: rmullinnix@nsd.org

**THE FOLLOWING DOCUMENTS ARE REQUIRED
AT TIME OF ENROLLMENT**

- ☐ District Enrollment Form
- ☐ Copy of Birth Certificate or Passport
- ☐ Proof of Residence (copy of utility bill or lease/mortgage indicating address & guardian name - if living in another person's home, advise Registrar for additional documentation requirements)
- ☐ Northshore School District required health forms:
 - ☐ Health Registration Form
 - ☐ Immunization report from physician's office
 - ☐ If applicable, Authorization for Medication form
- ☐ 7th and 8th grade students: Provide one of the following from prior school:
Withdraw Slip (if transferring after school year started)
Academic History or final report card (if transferring at beginning of school year)
- ☐ State Attendance Agreement
- ☐ Legal custody: Copy of the current court order or Parenting Plan.
- ☐ Request Transfer of Records

If your student is a current Special Education student:

- ☐ Completed Special Education Move-In packet
- ☐ IEP/504 records from prior school (if immediately available)

NMS Office Use Only

11/19 rm

New Student Packet:

- ☐ Bus Pass
- ☐ Planner
- ☐ Schedule
- ☐ School Map

New Parent Packet:

- ☐ ParentVue ☐ TouchBase ☐ Bus Schedule ☐ Bell Schedule
- ☐ NSD Calendars (sheet/wall) ☐ Attendance Card ☐ School Map
- ☐ PE Uniform Info ☐ Athletics Info ☐ Forms Envelope

- ☐ File/RN Labels ☐ Email Office ☐ W/D cc:Counselor
- ☐ Rec Req Sent ☐ Rec Req Rcvd ☐ OOD State tests ➤ District
- ☐ 504 cc:Counselor ☐ IEP cc: SP ☐ ELL: Copy to EE / ☐ Email to EE/JC
- ☐ Do Not Count (if applicable)

STUDENT ENROLLMENT FORM

NSD ID# _____
 CLASS OF _____
 ENTER DATE _____
 PROOF OF AGE _____

STUDENT INFORMATION

Please Print Clearly

Preferred last name:	Preferred first name:	Entering grade level:	Gender: Male Female X
Legal last name:	Legal first and middle name:	Has your student gone by any other name? yes no	
Birthdate: _____ Month Day Year Birth City State Country		If yes, what was the previous name? _____	

Home Address: _____ Unit# _____ City _____ Zip _____

Mailing address: _____ Unit # _____ PO Box _____ City _____ Zip _____
 (If different from above)

Student home phone: _____ Unlisted? yes no

Student cell phone (if applicable): _____

School Experience Data:

Has this student:

- previously attended the Northshore School District (NSD)? yes no If yes, school _____ Year _____
- been enrolled in any special education program served with an Individual Education Plan (IEP), OT, PT, Speech? yes no If yes, school _____ Year _____
- had a 504 Plan? yes no If yes, school _____ Year _____
- had an emergency care plan to address known medical issues? yes no
- been enrolled in ELL or ESL programs? yes no
- been enrolled in reading or math supports (LAP/LASER/Title 1)? yes no
- ever been suspended or expelled for disciplinary reason(s)? yes no
- had any history of violent or criminal behavior? yes no

Last school attended: _____ Dates: from _____ to _____ Grade level(s) _____

Street _____ City _____ State _____ Zip _____

Other schools attended (list most recent first)

School	City	State	Zip	Dates		Grade Levels
				From	To	

My child has a life threatening condition that requires a medication or treatment during the school day: Yes No
 Chapter 28A.210 RCW: Requires orders to be in place before starting school.

Previously enrolled in an early learning program? yes no If yes, preschool attended: _____ # of years: _____

If yes, check all that apply: NSD preschool other preschool playgroup childcare with family, friends, neighbors

- Is your student a foster child? yes no

For this purpose, a **foster child** is a child whose care and placement is the responsibility of the State or local Welfare agency **OR** who is placed by a court with a caretaker household.

STUDENT ENROLLMENT FORM

WASHINGTON STATE RACE AND ETHNICITY CATEGORIES: Please complete Part I and Part II

Part I: HISPANIC OR LATINO Is your student of Hispanic or Latino origin? yes no (If "yes" please check all that apply)

Argentine	Chilean	Cuban	Guyanese	Mestizo	Paraguayan	Spaniard
Bolivian	Colombian	Dominican	Honduran	Native	Peruvian	Surinamese
Brazilian	Costa Rican	Ecuadorian	Jamaican	Nicaraguan	Puerto Rican	Uruguayan
Chicano (Mexican American)	Guatemalan	Mexican	Panamanian	Salvadoran	Venezuelan	

Hispanic or Latino Write in: _____

Please note: These race and ethnicity categories are provided by the State of Washington and the Northshore School District is mandated to collect this information for every student under applicable State and Federal laws. If you do not self-identify, you will be contacted by the school who needs to collect this information for every student under applicable State and Federal laws.

Part II: What race(s) do you consider your student? You may check categories and/or use write-in--check all that apply

AMERICAN INDIAN or ALASKAN NATIVE

American Indian/Alaskan Native

American Indian (Write in): _____

Alaska Native (Write in): _____

Washington State Tribes:

Chinook Tribe
Confederated Tribes and Bands of the Yakama Nation
Confederated Tribes of the Chehalis Reservation
Confederated Tribes of the Colville Reservation
Cowlitz Indian Tribe
Duwamish Tribe
Hoh Indian Tribe
Jamestown S'Klallam Tribe
Kalispel Indian Community of the Kalispel Reservation
Kikiallus Indian Nation
Lower Elwha Tribal Community
Lummi Tribe of the Lummi Reservation
Makah Indian Tribe of the Makah Indian Reservation
Marietta Band of the Nooksack Tribe
Muckleshoot Indian Tribe
Nisqually Indian Tribe
Nooksack Indian Tribe of Washington
Port Gamble S'Klallam Tribe

Puyallup Tribe of the Puyallup Reservation
Quileute Tribe of the Quileute Reservation
Quinault Indian Nation
Samish Indian Nation
Sauk-Suiattle Indian Tribe of Washington
Shoalwater Bay Indian Tribe of the Shoalwater Bay Indian
Reservation Skokomish Indian Tribe
Snohomish Tribe
Snoqualmie Indian Tribe
Snoqualmoo Tribe
Spokane Tribe of the Spokane Reservation
Squaxin Island Tribe of the Squaxin Island Reservation
Steilacoom Tribe
Stillaguamish Tribe of Indians of Washington
Suquamish Indian Tribe of the Port Madison Reservation
Swinomish Indian Tribal Community
Tulalip Tribes of Washington

ASIAN

Asian	Malaysian
Asian Indian	Mien
Bangladeshi	Mongolian
Bhutanese	Nepali
Burmese/Myanmar	Okinawan
Cambodian/Khmer	Pakistani
Cham	Punjabi
Chinese	Singaporean
Filipino	Sri Lankan
Hmong	Taiwanese
Indonesian	Thai
Japanese	Tibetan
Korean	Vietnamese
Lao	

Asian Write in: _____

NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER

Native Hawaiian/Other Pacific Islander	
Carolinian	Palauan
Chamorro	Papuan
Chuukese	Pohpeian
Fijian	Samoa
i-Kiribati / Gilbertese	Solomon Islander
Kosraean	Tahitian
Maori	Tokelauan
Marshallese	Tongan
Native Hawaiian	Tuvaluan
Ni-Vanuatu	Yapese

Pacific Islander Write in: _____



STUDENT ENROLLMENT FORM

WASHINGTON STATE RACE AND ETHNICITY CATEGORIES (continued):

check all that apply

BLACK or AFRICAN AMERICAN

Black/ African American
African American
African Canadian

Caribbean

Anguillian
Antiguan
Bahamian
Barbadian
Barthélemois/Barthélemoises
(Saint Barthélemy)
British Virgin Islander
Caymanian (Cayman Island)
Cuba Dominican
Dominican (Dominican Republic)
Dutch Antillean
(Netherlands Antilles)
Grenadian
Guadeloupian
Haitian
Jamaican
Martiniquais/Martiniquaise
Montserratian
Puerto Rican

Caribbean Write in: _____

Black (Write in): _____

Central African

Angolan
Cameroonian
Central African
(Central African Republic)
Chadian
Congolese (Republic of the
Congo)
Congolese (Democratic
Republic of the Congo)
Equatorial Guinean
Gabonese
São Toméan
Principe

Central African Write in: _____

South African

Botswanan
Mosotho (Lesotho)
Namibian
South African
Swazi

South African Write in: _____

East African

Burundian
Comoran
Djiboutian
Eritrean
Ethiopian
Kenyan
Malagasy (Madagascar)
Malawian
Mauritian (Mauritius)
Mahoran (Mayotte)
Mozambican
Reunionese
Rwandan
Seychellois/Seychelloise
Somali
South Sudanese
Sudanese
Ugandan
Tanzanian (United
Republic of Tanzania)
Zambian
Zimbabwean

East African Write in: _____

Latin American

Argentine
Belizean
Bolivian
Brazilian
Chilean
Colombian
Costa Rican
Ecuadorian
El Salvadoran
Falkland Islander
French Guianese
Guatemalan
Guyanese
Honduran
Mexican
Nicaraguan
Panamanian
Paraguayan
Peruvian
South Georgia and the
South Sandwich Islands
Surinamese
Uruguayan
Venezuelan

Latin American Write in: _____

West African

Beninese
Bissau-Guinean
Burkinabé (Burkina Faso)
Cabo Verdean
Ivorian (Cote d'Ivoire)
Gambian
Ghanaian
Liberian
Malian
Mauritanian
Nigerien (Niger)
Nigerian (Nigeria)
Saint Helenian
Senegalese
Sierra Leonean
Togolese

West African Write in: _____

WHITE

White

Eastern European

Bosnian
Herzegovinian
Polish
Romanian
Russian
Ukrainian

Eastern European Write in: _____

Middle Eastern and North African

Algerian
Amazigh or Berber
Arab or Arabic
Assyrian
Bahraini
Bedouin
Chaldean

Copt
Druze
Egyptian
Emirati
Iranian
Iraqi
Israeli

Jordanian
Kurdish Kuwaiti
Lebanese
Libyan
Moroccan
Omani
Palestinian

Qatari
Saudi Arabian
Syrian
Tunisian
Yemeni

Middle Eastern Write in: _____

North African Write in: _____

White (Write in): _____

By law, a student (or the parent/guardian on behalf of the student) is not required to identify their race and/or ethnicity on school forms. However, if a student (or parent/guardian on behalf of the student) does not complete the two-part question on race and ethnicity, by law, school personnel must use 'observer identification' to select the race and ethnicity of the student.



Student Name _____

STUDENT ENROLLMENT FORM**PARENT/GUARDIAN INFORMATION**

Student lives with Both Parents Mother Father Mother/Stepparent Father/Stepparent
 Other (specify relationship) _____ Alternates Mom & Dad Emancipated Minor
 Joint custody? yes no
 Release student to noncustodial parent? yes no
 Is there a parenting plan? yes no **If yes, please provide school with a copy of the current parenting plan**

PRIMARY HOUSEHOLD INFORMATION (where student resides majority of the time)**Legal Parent/guardian #1 :**

Last name _____ First name _____ Relationship to Student _____
 #1 phone _____ #2 phone _____ email _____
 home cell work home cell work

Do you need an interpreter (for school meetings)? yes no
 Do you need official school materials to be translated? yes no
 If yes, in what language? _____

Military Affiliation check one box:

N - No military affiliation A - Active duty U.S. Armed Forces
 R- U.S. Armed Forces Reserves G - Active duty Washington National Guard

Parent/guardian #2 :

Last name _____ First name _____ Relationship to Student _____
 #1 phone _____ #2 phone _____ email _____
 home cell work home cell work

Do you need an interpreter (for school meetings)? yes no
 Do you need official school materials to be translated? yes no
 If yes, in what language? _____

Military Affiliation check one box:

N - No military affiliation A - Active duty U.S. Armed Forces
 R- U.S. Armed Forces Reserves G - Active duty Washington National Guard

SECONDARY HOUSEHOLD INFORMATION

Receive mailings? yes no
 Educational Rights? yes no Notes: _____

Address _____ Unit # _____ City _____ State _____ Zip _____

Secondary Household Parent/guardian #1:

Last name _____ First name _____ Relationship to Student _____
 #1 phone _____ #2 phone _____ email _____
 home cell work home cell work Student contact allowed? yes no

Do you need an interpreter (for school meetings)? yes no
 Do you need official school materials to be translated? yes no
 If yes, in what language? _____

Military Affiliation check one box:

N - No military affiliation A - Active duty U.S. Armed Forces
 R- U.S. Armed Forces Reserves G - Active duty Washington National Guard

Secondary Household Parent/guardian #2:

Last name _____ First name _____ Relationship to Student _____
 #1 phone _____ #2 phone _____ email _____
 home cell work home cell work Student contact allowed? yes no

Do you need an interpreter (for school meetings)? yes no
 Do you need official school materials to be translated? yes no
 If yes, in what language? _____

Military Affiliation check one box:

N - No military affiliation A - Active duty U.S. Armed Forces
 R- U.S. Armed Forces Reserves G - Active duty Washington National Guard

STUDENT ENROLLMENT FORM

ADDITIONAL INFORMATION

Siblings in NSD: Last name (if different) _____ First name _____

Living at Home

Birth date

yes no

yes no

yes no

Persons to contact in case of emergency who are authorized to pick up your student at school (if parent/guardian cannot be reached):

#1 Full Name _____

Phone _____
home cell work Relationship _____

#2 Full Name _____

Phone _____
home cell work Relationship _____

#3 Full Name _____

Phone _____
home cell work Relationship _____

#4 Full Name _____

Phone _____
home cell work Relationship _____

Daycare provider (circle if applicable): Before school only Before and after school After school only

Provider Name: _____

Address: _____

Daycare phone: _____

Comments: _____ Emergency contact? _____

RESIDENCY VERIFICATION

State law requires that a student reside within the District boundaries and be able to prove residency or have been approved for a waiver in order to enroll in school. To be enrolled in Northshore School district you will need to establish residency within the attendance boundaries of your neighborhood school. Residency is defined as the physical location where the student spends the majority of their time, at a minimum, where they consistently spend four nights per week. Parents/guardians must supply documentation as listed in one of the options below:

Government mail--at school discretion

Home owner's Insurance Policy Declaration

Property Tax Bill--must be received in the mail not printed off of website

Redacted 1099 or W-2

Unexpired Lease Agreement -must be signed by both parties

Utility Bill--accepted utilities include water, sewer, gas, electricity, cable or garbage. Cell phone bills are not accepted.

I acknowledge and agree to the following (please initial each statement below):

_____ My student resides with me at least four (4) nights per week at the address given, which is my primary residence.

Note: If your student does not reside with you at least four (4) nights per week at the address given, please initial here _____ and attach a written explanation of where and with whom your child resides each day of the week.

_____ I agree to notify the District/School within five (5) days when I change my residence or that of my student to a new address, either within or outside of the District.

_____ The District will investigate all cases where it has reason to believe that residency status has changed and/or false information has been provided, which may include the use of investigators to verify residency status. Verification may include home visits.

_____ Investigations that reveal students have enrolled on the basis of providing false information will be cause for revocation of the student's school assignment and disenrollment from the District.

By signing this form, I certify that all information is true and correct and that all documents submitted have not been altered or falsified in any way.

Parent/Guardian signature _____ Parent/Guardian (print) _____

Date _____



Student Name _____

STUDENT HOUSING QUESTIONNAIRE

The answers to the following questions can help determine the services this student may be eligible to receive under the McKinney-Vento Act 42 U.S.C. 11435. The McKinney-Vento Act provides services and supports for children and youth experiencing homelessness. All information will be kept confidential and will not be shared with anyone other than designated NSD staff.

1. CURRENT LIVING SITUATION:**DO YOU OWN/RENT YOUR OWN HOME/APARTMENT?**

Home owner

Renter

Co-Resident

Other

If owner or renter, skip to section 3.**If co-resident, complete co-residency form.****If other, please complete the remainder of this form.****If you do not own/rent your home, where are you and your family staying? Please check all that apply below:**

In an emergency / transitional shelter

With an adult not a parent or legal guardian or alone without an adult

Temporary in someone else's house or apartment with another family due to economic hardship or similar reason

Moving from place to place/couch surfing

In a motel / hotel

In a residence with inadequate facilities (no water, heat, electricity, etc.), abandoned building or substandard housing

A car, park, campsite, RV, tent or similar location

Other _____

2. STUDENT INFORMATION

Student(s): Last

First

Date of Birth:

Age:

Grade:

Name of School:

Month/Day/Year

_____	_____
_____	_____
_____	_____
_____	_____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Student is living with a parent or legal guardian

Student is unaccompanied (not living with a parent or legal guardian)

3. PARENT/GUARDIAN OR UNACCOMPANIED YOUTH INFORMATION**The undersigned certifies that the information provided above is accurate. PLEASE PRINT your information.**

Parent(s)/legal guardian(s):

(Or unaccompanied youth) _____

Address of current residence: _____

Phone number or contact number _____ Name of contact: _____

Print name of parent/legal guardian:(Or unaccompanied youth) _____

** I declare under penalty of perjury under the laws of the State of Washington that the information provided here is true and correct and understand that it will be verified. I authorize the release of information to the Northshore School District by State and local emergency and/or transitional housing programs, and/or other business or government agencies.*

*Signature of parent/legal guardian: _____ Date: _____

(Or unaccompanied youth)

**Office Managers and/or Registrars: If parent marked any box in Section 1, please forward a copy of this form to:
NSD MV Liaison, Ana Foy**



Office of Superintendent of Public Instruction (OSPI)
Home Language Survey

The Home Language Survey is given to *all* students enrolling in Washington schools.

Student Name:	Grade:	Date:
Right to Translation and Interpretation Services Indicate your language preference so we can provide an interpreter or translated documents, free of charge, when you need them.	All parents have the right to information about their child's education in a language they understand. In what language(s) would your family prefer to communicate with the school? _____	
Eligibility for Language Development Support Information about the student's language helps us identify students who qualify for support to develop the language skills necessary for success in school. Please Note: Testing may be necessary to determine if language supports are needed.	What language did your child learn first? _____ What language does your child use the most at home? _____ What is the primary language used in the home, regardless of the language spoken by your child? _____ Has your child received English language development support in a previous school? Yes No Don't Know	
Prior Education Your responses about your child's birth country and previous education: <ul style="list-style-type: none">• Give us information about the knowledge and skills your child is bringing to school.• May enable the school district to receive additional federal funding to provide support to your child. <i>This form is not used to identify students' immigration status.</i>	In what country was your child born? _____ Has your child ever received formal education outside of the United States? (Kindergarten – 12 th grade) Yes No If yes: Number of months: _____ Language of instruction: _____ When did your child first attend a school in the United States? (Kindergarten – 12 th grade) _____ Month Day Year	

Parent/Guardian Signature Required

_____	_____
Parent / Guardian Signature	Today's Date

**STUDENT HEALTH RECORD**

Student Name: (Last) _____ (First) _____ Birthdate: _____

State law requires that students with life-threatening conditions such as anaphylaxis, severe asthma, diabetes or seizures have a care plan completed prior to the first day of school. Contact the school nurse as soon as possible to complete the proper forms.

Does your student have a LIFE-THREATENING health condition? ☐ Yes ☐ No**MEDICAL HISTORY** (check all that apply)

<p>Life-Threatening Conditions: (Care plan is REQUIRED)</p> <p><input type="checkbox"/> Anaphylaxis (Epi-pen prescribed) Allergen/s:</p> <p><input type="checkbox"/> Diabetes Type 1</p> <p><input type="checkbox"/> Seizures – (Emergency medication required)</p> <p><input type="checkbox"/> Asthma – Severe</p> <p><input type="checkbox"/> Other Life-Threatening Condition:</p> <p>Congenital / Genetic</p> <p><input type="checkbox"/> Down Syndrome</p> <p><input type="checkbox"/> Fetal Alcohol Spectrum Disorder</p> <p><input type="checkbox"/> Please list:</p> <p>Blood / Hematology</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> Sickle Cell Disease Trait</p> <p><input type="checkbox"/> History of Severe Nosebleeds</p> <p><input type="checkbox"/> Other Blood Condition:</p> <p>Cardiac / Heart</p> <p><input type="checkbox"/> Heart Birth Defect</p> <p><input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> Other Cardiovascular Condition:</p> <p>Allergy, Immune, Endocrine, Metabolic and Nutritional</p> <p><input type="checkbox"/> Allergy – Food</p> <p><input type="checkbox"/> Allergy – Insect</p> <p><input type="checkbox"/> Allergy – Other List:</p> <p><input type="checkbox"/> Diabetes Type 2</p> <p><input type="checkbox"/> Other Endocrine, Immune, Nutritional or Metabolic:</p> <p>Gastrointestinal, Dental and Oral</p> <p><input type="checkbox"/> Celiac</p> <p><input type="checkbox"/> Food Intolerance List:</p> <p><input type="checkbox"/> Lactose Intolerance</p> <p><input type="checkbox"/> Encopresis</p> <p><input type="checkbox"/> Chronic Constipation</p> <p><input type="checkbox"/> Gastric Reflux</p> <p><input type="checkbox"/> Inflammatory Bowel Disease</p> <p><input type="checkbox"/> Irritable Bowel Syndrome</p> <p><input type="checkbox"/> Other Gastrointestinal, Liver, Dental, Oral Condition</p> <p>Musculoskeletal</p> <p><input type="checkbox"/> Juvenile Rheumatoid / Idiopathic Arthritis</p> <p><input type="checkbox"/> Please list:</p> <p>Cancer / Tumor</p> <p><input type="checkbox"/> Please list:</p>	<p>Nervous System</p> <p><input type="checkbox"/> ADHD / ADD diagnosed by:</p> <p><input type="checkbox"/> Autism Spectrum Disorder</p> <p><input type="checkbox"/> Cerebral Palsy</p> <p><input type="checkbox"/> Developmental Disability</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Headaches, Recurring</p> <p><input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Current <input type="checkbox"/> History Type:</p> <p><input type="checkbox"/> Traumatic Brain Injury</p> <p><input type="checkbox"/> Other Neurological Condition:</p> <p>Transplant</p> <p><input type="checkbox"/> List organ:</p> <p>Mental or Behavioral Health</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Sleep Disorder</p> <p><input type="checkbox"/> Other Mental or Behavioral Health Condition</p> <p>Respiratory / Breathing</p> <p><input type="checkbox"/> Asthma – Current</p> <p><input type="checkbox"/> Asthma – Ever Diagnosed</p> <p><input type="checkbox"/> Asthma – Exercised Induced</p> <p><input type="checkbox"/> Reactive Airway Disease</p> <p><input type="checkbox"/> Other Respiratory Condition:</p> <p>Skin</p> <p><input type="checkbox"/> Eczema or Contact Dermatitis or Psoriasis</p> <p><input type="checkbox"/> Other Skin Condition:</p> <p>Renal / Kidney</p> <p><input type="checkbox"/> Please list:</p> <p>Ear / Hearing</p> <p><input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Currently <input type="checkbox"/> Historically</p> <p><input type="checkbox"/> Hearing Impaired Hearing Aid/s Cochlear Implant</p> <p><input type="checkbox"/> Other Ear Condition:</p> <p>Eye / Vision</p> <p><input type="checkbox"/> Wears glasses / contacts</p> <p><input type="checkbox"/> Color Vision Deficit</p> <p><input type="checkbox"/> Visually Impaired</p> <p><input type="checkbox"/> Other Eye Condition:</p> <p>Other Health Concerns:</p> <p><input type="checkbox"/> Please list:</p>
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☐ No known health concerns.

Please initial _____

**STUDENT HEALTH RECORD**

Student Name: (Last) _____ (First) _____ Birthdate: _____

MEDICATIONS

Please report all medications that your student takes at home and/or at school.

Is medication needed at home? ☐ No ☐ Yes Please list: _____Is medication needed at school? ☐ No ☐ Yes Please list: _____**Complete REQUIRED
paperwork for medication at
school.***State law requires written permission from guardian and a health care provider before any medication (prescription and over-the-counter) may be taken at school. Forms are available from your school office or on our district website and must be completed annually.***Medical Devices**

- ☐ Vagal Nerve Stimulator
☐ Automatic Internal Cardiac Defibrillator
☐ Pacemaker
☐ Gastrostomy tube
☐ Jejunostomy tube
☐ Brace
☐ Prosthesis List:
☐ Other medical devices:

Stoma

- ☐ Gastrostomy
☐ Colostomy
☐ Tracheostomy
☐ Urostomy
☐ Other:

Physical Activity / Mobility Issues:

- ☐ Wheelchair
☐ Crutches
☐ Other List:

I understand that the information I provided will be shared with appropriate school staff who need to know in order to provide for the health and safety of my student. If parents/guardians or authorized emergency contacts cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgement of school authorities, I authorize and direct the school authorities to send the student to the hospital or healthcare provider most easily accessible. I understand that I will assume full responsibility for the payment of any services rendered. **I understand that Washington law requires that my student's immunizations are complete or conditional before starting school.** I give permission to my child's school to add immunization information to the Immunization Information System to help the school maintain my child's school record.

Parent/Legal Guardian Signature: _____ Date: _____

IMMUNIZATION VERIFICATION (Office use only)

WAIS # _____

CIS Series: ☐ Preschool ☐ Grade K-6 ☐ Grade 7 ☐ Grade 8-12☐ Immunization Status is COMPLETE on the WAIS Certificate of Immunization Status (CIS).**OR**☐ Immunization Status is CONDITIONAL on the WAIS CIS and the conditional status expiration date is after the first day of attendance.☐ Parent/Guardian has signed the conditional status acknowledgement on the CIS.**OR**☐ Student is not in WAIS. **Medically verified immunization records must be provided.**☐ Medically verified immunization records provided ☐ Permission to enter statement signed**OR**☐ Certificate of Exemption (COE) provided for all vaccines not in compliance on WAIS CIS or in WAIS.☐ COE is fully completed ☐ Permission to enter statement signed**OR**☐ Immunization Status is NOT COMPLETE on the WAIS CIS **Student may not start school until documentation of missing immunizations is received that will change the CIS status to COMPLETE or CONDITIONAL.**☐ Student added to School Module Roster: Grade: _____

Staff who verified immunizations: _____ Date: _____

Vaccines Required for School: Preschool -12th

August 1, 2022 to July 31, 2023



	DTaP/Tdap (Diphtheria, Tetanus, Pertussis)	Hepatitis B	Hib (<i>Haemophilus influenzae</i> type B)	MMR (Measles, mumps rubella)	PCV (Pneumococcal Conjugate)	Polio	Varicella (Chickenpox)
Preschool Age 19 months to <4 years on 09/01/2022	4 doses DTaP	3 doses	3 or 4 doses** (depending on vaccine)	1 dose	4 doses**	3 doses	1 dose***
Preschool/Kindergarten (including Transitional Kindergarten) Age =4* years on 09/01/2022	5 doses DTaP**	3 doses	3 or 4 doses** (depending on vaccine) (Not required at age ≥5 years)	2 doses	4 doses** (Not required at age ≥5 years)	4 doses**	2 doses***
Kindergarten through 6th Age ≥5 years on 09/01/2022	5 doses DTaP**	3 doses	Not Required	2 doses	Not Required	4 doses**	2 doses***
7th through 9th	5 doses DTaP** Plus Tdap at age ≥10 years	3 doses	Not Required	2 doses	Not Required	4 doses**	2 doses***
10th through 12th	5 doses DTaP** Plus Tdap at age ≥7 years	3 doses	Not Required	2 doses	Not Required	4 doses**	2 doses***

*Consistent with ACIP CDC Immunization Schedule. **Vaccine doses may be acceptable with fewer than listed depending on when they were given. ***Health care provider verification of history of chickenpox disease is also acceptable. See the Minimum Age and Interval Table on page 2 for required minimum age and spacing information of vaccine doses.

Find information on other vaccines that are recommended, but not required, for child care/preschool attendance at: www.immunize.org/cdc/schedules.

Review the Individual Vaccine Requirements Summary for more detailed information, located on our web page: www.doh.wa.gov/SCCI

To request this document in another format, call 1-800-525-0127.

Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

DOH 348-051 Dec 2021

Vaccine	Dose #	Minimum Age	Minimum Interval* Between Doses	Notes
Hepatitis B (Hep B)	Dose 1	Birth	4 weeks between dose 1 & 2	2 doses are acceptable if both doses are documented as adult doses of Recombivax HB* given between ages 11 and 15. The doses must be separated by at least 4 months. Completing the Hepatitis B series is recommended but not required for students 19 years of age and older.
	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 and Tdap)	Dose 1	6 weeks	4 weeks between dose 1 & 2	<p>A 6 month interval is recommended between dose 3 and dose 4, but a minimum interval of 4 months is acceptable. Dose 5 not needed if dose 4 on or after the 4th birthday and at least 6 months after dose 3</p> <p>DTaP can be given to children through age 6. If catch-up doses are needed at age 7 and older, Tdap is used followed by additional doses of Tdap or Td if needed.</p> <p>A Tdap booster dose is required for all students in grades 7-12.</p> <p>For students in 7th –9th grade, Tdap dose is acceptable if given on or after 10 years of age.</p> <p>For students in 10th—12th grades, Tdap dose is acceptable if given on or after 7 years of age.</p>
	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	—	
	Booster	10 years	—	
Haemophilus influenzae type B (Hib)	Dose 1	6 weeks	4 weeks between dose 1 & 2	<p>If all 3 doses of PedvaxHIB given, only need 3 doses total. Dose 3 must be ≥ 12 months of age.</p> <p>Only one dose required if the dose is given on or after 15 months of age.</p> <p>Age ≥ 5 years: Not required because not routinely given to children age 5 years and older.</p>
	Dose 2	10 weeks	4 weeks between dose 2 & 3	
	Dose 3	14 weeks	8 weeks between dose 3 & 4	
	Dose 4	12 months	—	
Pneumococcal Conjugate (PCV13)	Dose 1	6 weeks	4 weeks between dose 1 & 2	<p>Only one dose is required if the dose is given on or after 24 months of age.</p> <p>Age ≥ 5 years: Not required because not routinely given to children age 5 years and older.</p>
	Dose 2	10 weeks	4 weeks between dose 2 & 3	
	Dose 3	14 weeks	8 weeks between dose 3 & 4	
	Dose 4	12 months	—	
Polio (IPV or OPV)	Dose 1	6 weeks	4 weeks between dose 1 & 2	<p>Dose 4 not needed if dose 3 on or after the 4th birthday and at least 6 months after dose 2.</p> <p>OPV given on or after 04/01/16 cannot be accepted as a valid dose in the series.</p> <p>Completing the polio series is recommended but not required for students 18 years of age and older.</p> <p>For 12 grade minimum age and intervals see Individual Vaccine Requirements Summary link below</p>
	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 or MMRV)	Dose 1	12 months	4 weeks between dose 1 & 2	<p>MMRV (MMR + Varicella) may be used in place of separate MMR and varicella vaccines.</p> <p>Must be given the same day as varicella OR at least 28 days apart, also see* footnote.</p>
	Dose 2	13 months	—	
Varicella (Chickenpox) (VAR)	Dose 1	12 months	3 months between dose 1 & 2 (12 months through 12 years). 4 weeks between dose 1 & 2 (13 years and older)	<p>Recommended: 3 months between varicella doses, but at least 28 days minimum interval is acceptable. Healthcare provider verification of disease history is acceptable to document immunity.</p> <p>Must be given the same day as MMR OR at least 28 days apart, also see* footnote.</p>
	Dose 2	15 months	—	

*The 4 day grace period can be applied to all doses except between two doses of different live vaccines (such as MMR, MMRV, varicella, and Flumist).

See the Individual Vaccine Requirements Summary for more details about the schedules: <https://www.doh.wa.gov/SCCI>

DOH 348-051 Dec 2021

IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE 2022-2023

For the protection of your student, Washington State's School Immunization Law requires documentation of immunization at the time of school registration. **As of August 1, 2020, parents are required to provide medically verified immunization records for entry into school or preschool on or before the student's first day at school. Medically verified immunization records includes one or more of the following:**

- A Certificate of Immunization Status (CIS) printed from the Immunization Information System (IIS) (see page 2).
- A physical copy of the CIS form with a healthcare provider signature.
- A physical copy of the CIS with accompanying medical immunization records from a healthcare provider verified and signed by school staff.
- It is the responsibility of the parent/guardian to obtain the **required healthcare provider verified documentation** AND complete the form.

For more information: <http://www.doh.wa.gov/YouandYourFamily/Immunization>

Students WITHOUT documentation of medically verified immunization records will NOT be accepted for school attendance.

Minimum ENTRY requirements for school attendance are:

DTaP/DPT/Td: Diphtheria, Tetanus, Pertussis (Whooping Cough)

- **Preschool (< 4 years on 09/01/2022):** (4) doses.
- **Grades K-12 (Age 4 on 09/01/2022):** (5) doses or (4) acceptable of DPT/DTaP, with the last dose received on or after the fourth birthday.

Tdap: Vaccine booster for adolescent protection against Diphtheria, Pertussis and Tetanus

- **Grades 7-12: (1) dose.** To be valid, the dose must be received on or after the 10th birthday for 7th and 8th grade students, and on or after the 7th birthday for 9th-12th grade students.

Polio: Inactivated polio vaccine (IPV) or Oral polio vaccine (OPV-Sabin) in any combination, however OPV is only valid if it was given prior to 4/1/2016.

- **Preschool:** (3) doses.
- **K-Grade 8:** (4) doses if last dose on or after the 4th birthday and dose 3 & 4 separated by 6 months. (3) doses acceptable if last dose on or after the 4th birthday.
- **Grades 9-12:** (4) doses if all doses given before the 4th birthday. (3) doses acceptable with the last dose on or after the 4th birthday.

MMR: Measles, Mumps and Rubella are combined into one vaccine

- **Preschool:** (1) dose on or after the first birthday.
- **Grades K-12:** (2) doses of MMR. First dose on or after 1st birthday. Dose #2 at least 28 days after the first dose.

Hepatitis B

- **Preschool-Grade 12:** (3) doses. Dose 3 must be given on or after 24 weeks of age; minimum interval between Dose 1 and 3 of 16 weeks.

Varicella: Chickenpox

- **Preschool:** (1) dose on or after 1st birthday OR proof of illness/immunity with signed note from Health Care Provider.
- **Grades K-12:** (2) doses on or after 1st birthday and at least 28 days apart OR proof of illness/immunity with signed note from Health Care Provider.

Hib: Haemophilus Influenzae Type B

- **Preschool ONLY:** Number of doses depends on age and when the vaccine is given. The recommended schedule is 2 or 3 doses before 15 months OR 1 dose after 15 months.

PCV: Pneumococcal

- **Preschool ONLY:** 2-4 doses depending on age if given before 24 months. 1 dose if only dose given after 24 months.

Washington State Immunization Information System (WAIS)

Many medical providers enter vaccine dates into the statewide database. School nurses or assigned staff may view and search these records for missing immunizations. Your signature on the CIS form allows us to enter these dates onto your child's school record.

Parents can now print their own child's Certificate of Immunization Status (CIS) through a new web portal called MyIR at <https://wa.myir.net/>. This secure online system pulls data from the WA Immunization Information System (WAIS) and will auto populate the CIS with immunizations contained in the IIS. Parents can print, sign, and submit the CIS to the school or preschool/child care. Go to <http://www.doh.wa.gov/YouandYourFamily/Immunization> for more information about this new system.

Exemptions

A child may be exempted from the legal requirement of having any or all of the required doses of vaccines under exceptional circumstances. EXEMPTIONS are claimed as Medical, Religious or Personal. **Personal/philosophical exemptions are no longer accepted for the MMR vaccines.** A certificate of exemption form is available from the Department of Health at <https://www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization#exempt>, the school nurse or school office upon request. Medical and personal exemptions require the signature of parents/guardians AND a health care provider. **Students who have been exempted are susceptible to the disease(s) for which they did not receive adequate vaccine(s). Therefore, in the event of a disease outbreak, they may be excluded from school attendance for the duration of the outbreak.**

Where to Obtain Vaccinations:

Immunizations may be obtained from your private health provider, certain pharmacies or Community Health Centers. The Community Centers may have sliding fee scales and accept medical coupons. Contact the specific center for hours and fees. ****BRING YOUR IMMUNIZATION RECORDS WITH YOU.** You may also contact the school nurse at the school your child will attend for more information or assistance for any health needs.

Community Health Centers

The Community Health Centers in King and Snohomish Counties offer immunizations as part of a clinical visit. Call for information and/or appointment for medical services. Services are available on a sliding-fee scale, insurance and Apple Health accepted.

Community Health Center of Snohomish County-Everett -South Clinic: <https://www.chcsno.org/>
1019 112th St. SW
Everett, WA 98204 (425) 551-6200

Community Health Center of Snohomish County-Lynnwood Clinic: <https://www.chcsno.org/>
4111 194th St. SW
Lynnwood, WA 98036 (425) 835-5200

HealthPoint – Bothell: <https://www.healthpointchc.org/>
10414 Beardslee Blvd Suite 100
Bothell, WA 98011 (425) 486-0658

HealthPoint – Redmond: <https://www.healthpointchc.org/>
16225 NE 87th St. Together Center, Building B
Redmond, WA 98052 (425) 882-1697

The Community Health Access Program is a resource for medical/dental care for students and families in King County. Call 800.756.5437 or chap@kingcounty.gov for assistance with accessing health care & health care coverage for your family.



January 25, 2022

Dear Parent or Guardian:

As a parent, there is nothing more important than safeguarding your child's health. The Washington State Legislature requires us to make information available to you about meningococcal disease and human papillomavirus (HPV). Know the facts about these diseases and the vaccines available to protect your child.

Meningococcal Disease and Prevention

What is meningococcal disease?

Meningococcal disease is a serious bacterial infection. Fortunately, this life-threatening illness is rare, with only 20-30 cases reported each year in Washington. The most common symptoms of the disease include fever, cough, headache, and rash. It can cause meningitis (swelling of the covering of the brain and spinal cord). The disease spreads through close contact with an infected person. Teens and young adults are more likely to get meningococcal disease, especially if they live in group settings like college dorms.

How can I protect my child from meningococcal disease?

The meningococcal conjugate vaccine, or MCV4, prevents against four types of the disease. It is a 2-dose series recommended for all children between 11 and 12 years of age, and again at 16 to 18 years of age. The meningococcal B vaccine, or MenB, is recommended for some children with rare health conditions or who are at risk during a meningococcal B outbreak.

For more information about meningococcal disease and how to prevent it:

- Washington State Department of Health: www.doh.wa.gov/Immunization/DiseasesandVaccines/MeningitisMeningococcalDisease
- Centers for Disease Control and Prevention: www.cdc.gov/meningococcal

Human Papillomavirus (HPV) and Prevention

What is HPV?

HPV is a common virus. Most people exposed to HPV will never develop health issues. But for others, HPV causes major health problems, including cervical, anal, vulvar, mouth, and throat cancer. Most infected people have no symptoms and may spread the virus without knowing it. HPV spreads mainly through sexual contact.

How can I protect my child from HPV?

Make sure your child gets the HPV vaccine. The vaccine is highly effective. The HPV vaccine can prevent infection from some of the most common and serious types of HPV that cause cancer and genital warts. The vaccine does not get rid of existing HPV infections.

Who should get the vaccine and when should they get it?

Because the vaccine is more effective when given at younger ages, two doses of HPV vaccine are recommended for all boys and girls starting at ages 9 to 14. If boys or girls do not get the first dose of HPV vaccine before age 15, it is recommended as a three-dose series.

For more information on HPV, the vaccine, and cervical cancer:

- Washington State Department of Health: www.doh.wa.gov/hpv
- Centers for Disease Control & Prevention: www.cdc.gov/hpv

Where can I find the meningococcal and HPV vaccines?

Talk to your healthcare provider about the vaccines your child needs. In addition to meningococcal and HPV, your preteen should receive Tdap. Washington offers vaccines at no cost to kids through age 18. Providers may charge an office visit fee or administration fee to give the vaccine. If you can't afford these fees, you can ask to have them waived.

Sincerely,

Cindy Mato, Health and Nursing Supervisor



**Immunization Record Sharing with the Washington State Department of Health:
Washington State Immunization Information System (WAIIS)**

Our school is part of a state immunization record tracking system that includes immunization data from area doctors' offices and health care providers. This information system makes it much easier for us to get copies of your child's immunization record, a requirement for school entry under Washington State law. This information is used solely to help protect your child and prevent disease by improving the quality and timeliness of records and services in our community. The information can only be shared with entities authorized by Washington law (RCW 70.02) to receive it, such as doctors, nurses, public health entities and schools (Family Educational Records Privacy Act). In addition, the information can **only** be used for immunization record keeping.

I authorize the Northshore School District to release my child's immunization record to the Washington State Immunization Information System. I understand this information can only be used to improve the quality and timeliness of immunization records and to assist with determining immunization compliance. This includes any immunization information the school currently has plus any it may obtain during my child's attendance in the Northshore School District.

Child's Name: _____ Date of Birth: ____/____/____

Parent's signature: _____ Date: ____/____/____

Please return to the School Nurse



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		X _____ Parent/Guardian Signature Required if Starting in Conditional Status	
Date		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 (<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)						
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: <input type="checkbox"/> A verified history of varicella (chickenpox) disease. <input type="checkbox"/> 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
<input type="checkbox"/> 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).

DOH 348-013 November 2019

AUTHORIZATION FOR MEDICATION



Northshore
School District
3416 F-1

The following section is to be completed by the PARENT/GUARDIAN: (please print)

Student's Name: _____ Birth Date: _____ Sex: M ☐ F ☐

School: _____ Grade: _____

Health Care Provider (HCP): Name: _____

Address: _____ Phone: _____ Fax: _____

- ⇒ I request that my child be assisted by authorized personnel in taking the medication prescribed below at school, or be permitted to self-medicate according to Health Care Provider (HCP) instructions and School District Policy 3416
- ⇒ I understand that my signature on this form constitutes a waiver by me to the school district and authorized supervising personnel for liability for adverse reaction when medication is administered in the proper manner.
- ⇒ Changes to the time and/or dose of medication require written authorization from the HCP and Parent/guardian.
- ⇒ I understand that a medication dosage could be delayed or missed due to unexpected circumstances or changes in the student's schedule. If I am unable to accept this condition the district is not obligated to honor the request for administration of medication by school staff.
- ⇒ **Medication must be provided to the school in a properly labeled prescription bottle or the original over-the-counter container. Ask the pharmacist to supply a second prescription bottle for school use.**
- ⇒ I give permission for exchange of information between the school and HCP.

Parent/Guardian Signature Date Home Phone Emergency Phone

- ☐ I request permission for my child to self-carry this medication during any school-sponsored activities occurring before/after school or overnight outdoor education programs.
- ☐ I request permission for my child to self-administer medication for asthma or anaphylaxis. By law my signature indicates that I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and parents or guardians shall hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student (3419).

Parent/Guardian Signature

The following section is to be completed by the HEALTH CARE PROVIDER: (please print)

Diagnosis or reason for medication: _____

	<u>Name of Medication</u>	<u>Dose</u>	<u>Route</u>	<u>Time/Frequency</u>
#1	_____	_____	_____	_____
#2	_____	_____	_____	_____
#3	_____	_____	_____	_____

If medication is to be given AS NEEDED, describe instruction: _____

Significant side effects: _____

Is child authorized to carry and self-medicate? Yes ☐ No ☐

If yes, for asthma and anaphylaxis medication, I have trained this student in the proper Administration and Frequency of use.

If ordered and the School Nurse is NOT AVAILABLE (e.g. field trip, after school activity etc.):

*Epinephrine Auto-injector WILL be given for ANY allergy symptoms or known ingestion.

*Glucagon, Midazolam and Diastat WILL NOT be administered by other school staff, 911 will be called.

Start Date: _____ Discontinue Date: _____ or end of school year ☐

Health Care Provider Signature Date Phone

Return to: School Nurse Ronit Gourarie Phone # 425-408-6706 Fax # 425-408-6702
School Address: 12101 NE 160th Street Bothell, WA 98011



NORTHSHORE SCHOOL DISTRICT

MEDICATION GUIDELINES

If your student will be taking ANY medication at school, you must confer with the school nurse.

The Northshore School District recommends that medication be taken at home whenever possible. We recognize, however, that in some cases it is essential that medication be administered during the school day. For the protection of all the students and to comply with Washington state law, the district has a policy and procedures in place for the handling of ALL medications in the schools.

Please do not put any kind of medicine, including aspirin, vitamins, and cough drops in your child's lunch box, backpack or pockets. Unidentified medicine can never be given at school.

School Staff Administered - The following conditions must be met:

- ✓ All medications, whether over-the-counter or prescription, need a current Northshore Medication Authorization Form signed by the student's Health Care Provider/dentist **and** parent/guardian.
- ✓ Medication must be delivered to school in a properly labeled prescription or original over-the-counter container. The student's name must be on the label with proper identification of the drug, dosage, and directions for administration.
- ✓ A quantity sufficient for one month **only** can be sent to school.
- ✓ The medication order is effective for the **current** school year only.
- ✓ If changes in the medication order occur, the parent is responsible for notifying the school and providing verification from the Health Care Provider/dentist.

Field Trips: For students on daily medication, request an extra labeled empty bottle from your pharmacy that can be used for field trips.

Student Self-Administered Medication - The following conditions must be met:

In appropriate cases and with the knowledge of the school nurse, the parent/guardian can delegate the responsibility for self-administration of medication to the student. In doing so, the parent releases the school district from any obligation to monitor the student and assumes full responsibility for the student's use of the medication.

- ✓ Self-Administration does not apply to controlled substances, e.g. codeine, vicodin
- ✓ The student may only carry a one-day supply (1 - 2 doses) of the medication.
- ✓ The medication must be in the original container.
- ✓ The student must have written permission to self-medicate signed by the parent/guardian.

Medication to be self-administered for more than fifteen (15) consecutive days whether over-the-counter or prescription requires a current Northshore Medication Authorization Form signed by the student's Health Care Provider/dentist and parent/guardian stating that the student may self-medicate. The student must also demonstrate his/her ability to the School Nurse to correctly evaluate his/her symptoms and use the medication appropriately.

Asthma and Anaphylaxis medications:

When a parent requests that his/her student be allowed to self-administer medication for asthma and/or anaphylaxis (severe allergic reaction), a Medication Authorization Form must be filled out and signed by the Health Care Provider **and** parent/guardian. The permission form must contain a treatment plan for what to do in case of an emergency.

The Health Care Provider must also provide training for the student to recognize symptoms and the correct use of medications. Additionally the student must demonstrate his/her ability to correctly evaluate his/her symptoms and use of medications to the school nurse including how to access help when needed. (RCW 28A.210.370 and School District Policy 3419)

Dear Parent(s)/Guardian(s),

SCHOOL ATTENDANCE IS REQUIRED BY STATE LAW

- State law requires children from age 8 to 17 to attend school.
- Children that are 6- or 7-years-old, who are enrolled in school, must
- also attend school.
- Youth who are 16 or older may be excused from attending school if they meet certain requirements.

If your child is going to be absent, please contact the school.

SCHOOL'S DUTIES UPON A STUDENT'S ABSENCES

- If your child has two **unexcused** absences in one month, state law (RCW 28A.225.020) requires we schedule a conference with you and your child.
- In elementary school after five *excused* absences in any month, or ten or more *excused* absences in the school year, the school district is required to contact you to schedule a conference. A conference is not required if your child has provided a doctor's note, or pre-arranged the absence in writing, and plans are in place so your child does not fall behind academically.
- If your child has **seven unexcused** absences in any month or **ten unexcused** absences within the school year, we are required to file a Petition with the Juvenile court, alleging a violation of RCW 28A.225.010, the mandatory attendance laws. You and your child may need to appear in Juvenile Court.

DID YOU KNOW?

- Attending school on-time, all day, every day will give your child the best chance of graduating from high school.
- Starting in kindergarten, missing on average just 2 days a month, whether excused or unexcused, makes it more likely that your child will not meet academic standards in math and reading by third grade.
- By 6th grade, absenteeism is one of three signs that a student may drop out of high school.
- Absences can be a sign that a student is losing interest in school, struggling with school work, dealing with a bully or facing some other potentially serious difficulty.
- By 9th grade, regular attendance is a better predictor of high school graduation rates than 8th grade test scores.

WHAT YOU CAN DO

- Don't let your child stay home unless they are truly sick, such as fever, vomiting, diarrhea, or a contagious rash.
- Avoid appointments and travel when school is in session.
- Keep track of your child's attendance. Missing more than 9 days, excused or unexcused, could put your child at risk of falling behind.
- Set a regular bedtime and morning routine as well as finishing homework and packing backpacks the night before.
- Have a back-up plan in place with family members, neighbors, or other parents for getting your child to school in case something comes up.

If you are struggling to get your child to school for any reason, we are here to support you and work with you towards possible solutions. Please do not hesitate to contact the school to schedule an appointment to discuss your child's attendance.

Your signature below indicates that you have read (or someone read it to you) and understand this letter.

Print Name: _____, Date: ____/____/____

Signature: _____

Student Name: _____