Kids & Critters Christian Preschool

Child Care Registration	Date child entered care	Date child left care	
Child's name Last First Middle	Name (Nickname) used	Birthdate	
Street address		City	Zip code
Child's parent/guardian name	home phone # ( ) -	cell phone# ( ) -	alternative phone # ( ) -
Street address		City	Zip code
Address where you can be reached while child is in care		City	Zip code
Child's parent/guardian name	home phone # ( ) -	cell phone# ( ) -	alternative phone # ( ) -
Street address		City	Zip code
Address where you can be reached while child is in care		City	Zip code

Other than you, who else has permission to pick up your child?

Name	Address	Telephone number
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -

In case of an emergency, I give permission for any of the following individuals to be contacted and my child may be released to any of them.
Parent/Guardian signature:

Name	Address	Telephone number
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -

Who does not have permission to pick up your child? If applicable (A copy of supporting court document must be on file)	
Name	Reason

Child's health information		
Date of child's last physical exam:	Child's health care provider	Telephone number ( ) -
Street address	City	Zip code

Special health problems? Yes or no? If yes, specify.	Allergies, including drug reactions Yes or no? If yes, specify.
Regular medications? Yes or no? If yes, specify.	Other important information Yes or no? If yes, specify.
Child's dentist's name	Telephone number ( ) -
Street address	City Zip code

Child's medical insurance coverage	
Insurance company name	Member/policy number
Policy holder name	Employer name
Insurance company name	Member/policy number
Policy holder name	Employer name

Consent to medical care and treatment of minor children

I give permission that my child,_____, may be given first aid/emergency treatment by a the child care licensee and/or qualified staff at:
Name of Licensee KCC PRESCHOOL,
Address of Licensee 8304 NE 162nd Ave., Vancouver, WA 98682

Parent/guardian signature	Date	Parent/guardian signature	Date

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.
I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.
I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian signature	Date	Parent/guardian signature	Date

Kids & Critters Christian Preschool

Welcome to **Kids & Critters Christian Preschool** where children of any race, color, sex, national or ethnic origin are welcome.

If your child speaks another language besides English, please list which one(s) _____

Please make sure to keep us updated on any new immunization your child gets while in our care.

This is a non-smoking atmosphere.

Kids & Critters is distinctively and thoroughly a Christian program. The Bible based curriculum is non-denominational and permeates the entire Preschool program. Children are instructed and cared for by Christian teachers. The day's activities include prayer, Bible stories and songs, and character development.

PARENT RELEASE:

I have read the above statements, understand and allow my child to participate in Kids & Critters Christian Preschool programs and activities.

_____ _____

Parent Signature Date

E-mail address: _____

Mom's cell # _____

Dad's cell # _____

Kids & Critters Christian Preschool

FINANCIAL AGREEMENT for _____

PAYMENT OF FEES: I understand the enrollment fee is non-refundable.
I understand the first month's tuition must be received before schooling begins and is due by the 25th for the next month. Checks should be made out to "**Kids & Critters Christian Preschool or KCC Preschool**." A late payment fee of $5.00 per day will be assessed when payment is received after the 1st of the month unless other arrangements have been made. There will be a $45 fee applied for any returned checks.

- Monthly tuition will be_____
- for the days & hours of_____

HOLIDAYS AND SCHEDULED SCHOOL CLOSURES: I understand the Kids & Critters program will observe the following holidays during which time the school will be closed: Labor Day; Veteran's Day; Thanksgiving and the day before and after; Two weeks at Christmas & New Year's; Martin Luther King Jr. Day; President's Day (observed) and the Friday before; One week for Spring Break; Memorial Day.

These closures are already factored into the above monthly payment; you are not charged for them!

ABSENT DAYS: Our operation is dependent upon your tuition payments; therefore there is no billing adjustment for absences, such as illness, weather, or personal plans.

TERMINATION: If there becomes a need to discontinue services, Kids & Critters reserve the right to terminate services to a child at any time. There will be a two-week trial period at the beginning of school to see how things are going for both parties. If you wish to discontinue this contract, please provide us with at least two (2) weeks written notice prior to your child leaving.

RELEASES: Please initial the following

_____ If emergency medical care is necessary, I give Kids & Critters permission for emergency medical transportation and any treatment deemed necessary by a physician and/or local hospital at parent expense (see attached "Authorization for Treatment"). (All efforts to communicate with parents will be done first)

_____ I hereby grant permission for my child to participate in all activities.

_____ I hereby release and hold harmless the Kids & Critters program and its staff for any loss or damage to toys, clothes or other personal articles.

_____ I hereby release and hold you, your agents and employees harmless from any and all claims, damages, or liabilities to or damage by my child which are not a result of gross negligence by Kids & Critters program, its agents, or employees.

(optional)

_____ I give my permission for our name, address, and phone number to be distributed in a class directory.

_____ I give my permission for photos and videos to be used in promotional material for Kids & Critters.

By signing below, I acknowledge that I have read, understand, and consent to the above Financial Agreement and releases.

_____	_____	_____
Signature of Parent or Guardian		Date
_____	_____	_____
Signature of Parent or Guardian		Date
_____	_____	_____
Signature of 3rd party responsible for financial account		Date
_____	_____	
One receiving paperwork	Owner	

Kids & Critters Preschool

Medical History for _____ Age _____

Past illness(es) your child has had:

_____ Chicken Pox
Date: _____
_____ German Measles
_____ Other, please specify _____

_____Measles
_____Mumps
_____Whooping Cough

Previous Hospitalization? _____

Allergies? If so, please describe specific reaction: _____

_____

Is your child in the care of a doctor or on medication? If so, please explain: _____

_____

Regular yearly health exams are a part of maintaining well children. What is the date of your child's last physical exam or medical appointment? _____

Please give an evaluation of the overall health of your child at the present: _____

_____

Immunization **MUST BE** complete before admission. Refer to the State Certificate of Immunization Status.

ANY and **ALL** medications must have a parent signature. We have a standard form to use for administration of medications. For your convenience, some over-the-counter items can be administered with a parent signature, including cough syrup (NO cough drops), sunscreen, etc.

Please read the Parent Handbook on Health and Emergency Policy.

Young children typically are ill 5-8 times per year, even more if this is their first preschool experience while their immune system is getting stronger. Please plan back-up care **TODAY** for those times.

For preventative measures, please have your child wash his/her hands upon entering and leaving Kids & Critters Christian Preschool daily.

Thank you for your assistance.

Kids & Critters Christian Preschool

Social Information for _____
(Child's Name)

Brothers and sisters of child:

Name _____Date of Birth_____ School grade_____

Name _____Date of Birth_____ School grade_____

Names of other household members: _____

Does your child prefer to: _____play alone _____with playmates
_____with sibling(s) _____with adults

Does your child have any pets? If so, what kind? _____

What are your child's favorite indoor activities? _____

_____

What are your child's favorite outdoor activities? _____

_____

List your child's favorite toys, play equipment, and books _____

_____

Does your child need bathroom reminders? _____

Would you judge your child to be: _____Easily managed _____Fairly easily managed

_____Difficult to manage (please explain on next line)

_____

Are there any special circumstances in the family which may be a factor in your child's present behavior (divorce, death, new baby, recent move, hospitalization, etc.)? If so, please explain:

_____

In what ways would you like to see your child develop during this next year in our program?

_____

Please add any additional comments, which you feel, will help us know your child better.

_____

Thank you very much for informing us about your child.

Certificate of Immunization Status (CIS)

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

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

Child's Last Name:	**First Name:**	**Middle Initial:**	**Birthdate (MM/DD/YYYY):**

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

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

Documentation of Disease Immunity (Health care provider use only)

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

I certify that the child named on this CIS has:
□ A verified history of varicella (chickenpox) disease.
□ Laboratory evidence of immunity (titer) to disease(s) marked below.

□ Diphtheria	□ Hepatitis A	□ Hepatitis B
□ Hib	□ Measles	□ Mumps
□ Rubella	□ Tetanus	□ Varicella

□Polio (all 3 serotypes must show immunity)

►

Licensed Health Care Provider Signature Date

►

Printed Name

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

Health Care Provider or School Official Name: _____ Signature: _____ Date:_____
If verified by school or child care staff the medical immunization records must be attached to this document.

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

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

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

Acceptable Medical Records
All vaccination records must be medically verified. Examples include:

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

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

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

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

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://www.cdc.gov/vaccines/terms/usvaccines.html

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

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

DOH 348-013 November 2019

Certificate of Exemption—Personal/Religious

For School, Child Care, and Preschool Immunization Requirements

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

NOTICE: A parent or guardian may exempt their child from the vaccinations listed below by submitting this completed form to the child's school and/or child care. A person who has been exempted from a vaccination is considered at risk for the disease or diseases for which the vaccination offers protection. An exempted child/student may be excluded from school or child care settings and activities during an outbreak of the disease that they have not been fully vaccinated against. Vaccine-preventable diseases still exist, and can spread quickly in school and child care settings. Immunization is one of the best ways to protect people from getting and spreading diseases that may result in serious illness, disability, or death.

Personal/Philosophical or Religious Exemption

I am exempting my child from the requirement my child be vaccinated against the following disease(s) to attend school or child care. (Select an exemption type and the vaccinations you wish to exempt your child from):

PERSONAL/PHILOSOPHICAL EXEMPTION*

☐ Diphtheria	☐ Hepatitis B	☐ Hib	☐ Pneumococcal
☐ Polio	☐ Pertussis (whooping cough)	☐ Tetanus	☐ Varicella (chickenpox)

***Measles, mumps, or rubella may not be exempted for personal/philosophical reasons per state law**

RELIGIOUS EXEMPTION

☐ Diphtheria	☐ Hepatitis B	☐ Hib	☐ Pneumococcal
☐ Polio	☐ Pertussis (whooping cough)	☐ Tetanus	☐ Varicella (chickenpox)
☐ Measles	☐ Mumps	☐ Rubella	

Parent/Guardian Declaration

One or more of the required vaccines are in conflict with my personal, philosophical, or religious beliefs. I have discussed the benefits and risks of immunizations with the health care practitioner (signed below). I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

X_____ _____ _____

Parent/Guardian Name (print) | Parent/Guardian Signature | Date

Health Care Practitioner Declaration

I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child. I certify I am a qualified MD, ND, DO, ARNP, or PA licensed in Washington State.

X_____ _____ _____

Licensed Health Care Practitioner Name (print) | Licensed Health Care Practitioner Signature | Date

☐ MD ☐ ND ☐ DO ☐ ARNP ☐ PA Washington License #_____

RELIGIOUS MEMBERSHIP EXEMPTION

Complete this section ONLY if you belong to a church or religion that objects to the use of medical treatment. Use the section above if you have a religious objection to vaccinations but the beliefs or teachings of your church or religion allow for your child to be treated by medical professionals such as doctors and nurses.

Parent/Guardian Declaration

I am the parent or legal guardian of the above-named child. I affirm I am a member of a church or religion whose teaching does not allow health care practitioners to give medical treatment to my child. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

X_____ _____ _____

Parent/Guardian Name (print) | Parent/Guardian Signature | Date

Certificate of Exemption—Medical

For School, Child Care, and Preschool Immunization Requirements

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

NOTICE: This form may be used to exempt a child from the requirement of vaccination when a health care practitioner has determined specific vaccination is not advisable for the child for medical reasons. This form must be completed by a health care practitioner and signed by the parent/guardian. An exempted child/student may be excluded from school or child care during an outbreak of the disease they have not been fully vaccinated against. Vaccine preventable diseases still exist, and can spread quickly in school and child care settings.

Medical Exemption

A health care practitioner may grant a medical exemption to a vaccine required by rule of the Washington State Board of Health only if in their judgment, the vaccine is not advisable for the child. When it is determined that this particular vaccine is no longer contraindicated, the child will be required to have the vaccine (RCW 28A.210.090). Providers can find guidance on medical exemptions by reviewing Advisory Committee on Immunization Practices (ACIP) recommendations via the Centers for Disease Control and Prevention publication, "Guide to Vaccine Contraindications and Precautions," or the manufacturer's package insert. The ACIP guide can be found at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

*Please indicate which vaccination the **medical** exemption is referring to by disease. If the patient is not exempt from certain vaccinations, mark "not exempt.":*

Disease	Not Exempt	Permanent Exempt	Temporary Exempt	Expiration Date for Temporary Medical
Diphtheria	☐	☐	☐	
Hepatitis B	☐	☐	☐	
Hib	☐	☐	☐	
Measles	☐	☐	☐	
Mumps	☐	☐	☐	
Pertussis	☐	☐	☐	
Pneumococcal	☐	☐	☐	
Polio	☐	☐	☐	
Rubella	☐	☐	☐	
Tetanus	☐	☐	☐	
Varicella	☐	☐	☐	

Health Care Practitioner Declaration

I declare that vaccination for the disease(s) checked above is/are not advisable for this child. I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child. I certify I am a qualified MD, ND, DO, ARNP or PA licensed in Washington State, and the information provided on this form is complete and correct.

X _____ _____ _____

Licensed Health Care Practitioner Name (print) | Licensed Health Care Practitioner Signature | Date

☐ MD ☐ ND ☐ DO ☐ ARNP ☐ PA Washington License #_____

Parent/Guardian Declaration

I have discussed the benefits and risks of immunizations with the health care practitioner granting this medical exemption. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

X _____ _____ _____

Parent/Guardian Name (print) | Parent/Guardian Signature | Date