



Lynden Cooperative Preschool Registration Form

Class _____
Reg Fee _____
Supply Fee _____

Child's Name _____
Last First MI

Child's Birth Date _____ Age _____ Gender _____

Parent/Guardian

Parent/Guardian

Name _____

Name _____

Address _____

Address _____

Phone _____

Phone _____

Cell _____

Cell _____

Work _____

Work _____

Email _____

Email _____

Select one of the following:

- | | |
|--|---|
| _____ Toddler Class (18-36 months old) | \$585.00 / 9 months = \$65.00 per month |
| _____ Preschool (3-4 years old) | \$945.00 / 9 months = \$105.00 per month |
| _____ Pre-Kindergarten (4-5 years old) | \$1260.00 / 9 months = \$140.00 per month |

These figures are subject to change based upon finalization of annual school budget

A \$75.00 non-refundable Registration Fee must accompany application.

****Registration Fee for Toddler Class is \$35.00****

Supply Fee: \$50.00 Preschool \$25.00 Toddler

Please Note:

1. The school year is September through May. Enrollment is a 9 month commitment
2. If a minimum number of students is not met, your registration fee and any tuition paid will be fully refunded.
3. *Parent or Guardian must attend Toddler Class with child
4. Tuition is due on the first day of class each month and no later than the 5th of each month. A \$15.00 late fee is assessed after the 5th. A \$10.00 fee is assessed for returned checks.
5. Tuition costs are figured on an annual basis and prorated over a 9 month period. Tuition is paid monthly from September to May but may also be paid in advance or in less frequent, larger payments.
6. As an affiliate of Whatcom Community College (WCC) parents are automatically enrolled in WCC 3 credit parenting class. Fees are included in the preschool tuition. In return you receive student benefits and use of all WCC facilities.
7. **30 day written notice must be given to the Registrar prior to withdrawing your child from the program.**



Lynden Cooperative Preschool Field Trip/ Child Release/ Photo Release

Child's Name _____

Birth Date _____

I authorize the release of my child to the following adults during the school year:

Please note: Exceptions require written permission from the custodial parent before your child's release.

Are there any restraining orders in effect: YES NO

PLEASE ATTACH A COPY OF THE RESTRAINING ORDER.

Permission to Photograph

I give permission for my child to be photographed or video taped in scheduled preschool activities. Such photographs may be used by LCPS or WCC for publicity or educational purposes. Children will not be named.

Parent/ Guardian _____ Permission Declined: _____
Signature Date Signature

Field Trip Permission

My child has my permission to go on field trips with LCPS. I will be notified of all trips and will make arrangements for transportation of my child to and from said trips.

Parent/ Guardian _____
Signature Date

Field Trip Insurance Verification

I am able to drive others: YES / NO

I agree to be eligible to be a volunteer driver. I agree to hold harmless LCPS, it's board, employees & staff from any and all claims, liabilities, damages or expenses arriving directly or indirectly from use, maintenance or ownership of my vehicle.

Signature _____ Auto Insurance Co _____
Policy _____ Term of Coverage _____

Include a copy of your driver's license with your registration materials.



Lynden Cooperative Preschool

Consent to Emergency Medical Treatment

Child's Name _____

Birth Date _____

I hereby give permission that my child may be given emergency treatment by qualified staff at LCPS. I further authorize & consent to medical, surgical & hospital care, treatment & procedures performed by a licensed medical professional when deemed necessary or advisable by the medical professional when I cannot be contacted. I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance to an emergency center for treatment.

I assume full financial responsibility for services rendered.

“I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.”

Parent/ Guardian _____
Signature Date

Regular medications: _____

Allergies & drug reactions: _____

Symptoms of reaction: _____

Response to reaction: _____

Date of last tetanus shot: _____

Other health information: _____

Child's Physician: _____ Physician's Phone: _____

Emergency Contact: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Out of Area Contact: _____ Phone: _____

Include a completed Certificate of Immunization Status or Certificate of Exemption (signed by a physician) with your registration materials. Forms available from Registrar or online.



Lynden Cooperative Preschool Social History

Child's Name _____

Birth Date _____

List child's previous group experience:

What activities does your child enjoy?

What concerns do you have about your child that their teacher should know?

What do you enjoy most about your child?

Why did you choose this parent cooperative school?

List 3 goals for you child:

- 1.
- 2.
- 3

Siblings & Other Children at Home

Parent Interests or Strengths. Please list any particular interests, talents or strengths you have that you could share with the group. Do you play an instrument? Enjoy sewing? Have art training? Tell stories? Enjoy cooking? Etc.

Do you foresee any situation that will interfere with your ability to participate in co-op activities during the school year?



Lynden Cooperative Preschool Parenting Education Agreement

Child's name _____ Birth date _____

1. I will enroll in the adult parenting education class and pay the tuition required by WCC.
2. I will participate in the school as a working parent as required (Typically 2 to 3 times per month per child)
3. I will perform my required duties of my assigned parent job and/or board position which entails a time commitment average of 3.5 hours per month.
4. I will attend monthly parenting education classes
5. I will read and abide by the handbook, rules, and bylaws of the school
6. I will complete a health statement, immunization records and sign an emergency medical release form.
7. I will fulfill my fundraising commitment as determined each year by the board of directors. For example: previous years were a \$150 per family responsibility.
8. I will participate in classroom cleaning sessions 2 times throughout the year. For example, previous years were 1)from 6 to 8pm the last Thursday in December in place of a December parent meeting and 2)the last Thursday in May in place of a May parent meeting.
9. I agree to pay tuition whether or not my child attends every day.
10. I agree to give 30 days written notice to the registrar if I choose to withdraw my child prior to the end of the school year.
11. I agree to keep my child home if there are signs of a cold or other communicable diseases.
12. I will complete the required health and safety orientation.

Parent/Guardian _____
Signature Printed Date

WCC encourages all parents/guardians to participate in the cooperative experience.



Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Office Use Only:	
Reviewed by: _____	Date: _____
Signed Cert. of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

Child's Last Name: _____	First Name: _____	Middle Initial: _____	Birthdate (mm/dd/yyyy): _____	Sex: _____	I certify that the information provided on this form is correct and verifiable.
Symbols below: ◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only				Parent/Guardian Name (please print): _____	

Vaccine	Dose	Date		
		Month	Day	Year
◆ Hepatitis B (Hep B)				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)				
	1			
	2			
● Haemophilus influenzae type b (Hib)				
	1			
	2			
	3			
	4			
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date		
		Month	Day	Year
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox) or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			
Office Use Only: Immunization information updated and verified with parent/guardian permission:				
Printed Staff Name	Date	Printed Staff Name	Date	
Printed Staff Name	Date	Printed Staff Name	Date	

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

1) Chickenpox disease verified by printout from CHILD Profile Immunization Registry
Must be marked by printout (not by hand) to be valid.

2) Chickenpox disease verified by Health Care Provider (HCP)
If you choose this box, mark 2A OR 2B below.
 2A) Signed note from HCP attached OR
 2B) HCP signed here and print name below:

 Licensed health care provider (HCP) Signature _____ Date _____
 (MD, DO, ND, PA, ARNP)
 HCP Printed Name: _____

3) Chickenpox disease verified by school staff from CHILD Profile Immunization Registry
If you choose this box, staff must initial that parent or guardian approves: _____ (initial) _____ (date)

4) Chickenpox disease verified by parent*
If you choose this box, fill in the date or child's age when he or she had the disease:
 Age/Date of disease: _____
 *Can ONLY verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.
Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. **Signed lab report(s) MUST also be attached.**

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

Licensed health care provider (HCP) Signature _____ Date _____
 (MD, DO, ND, PA, ARNP)
 HCP Printed Name: _____

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

Vaccine	Dose	Date		
		Month	Day	Year
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
DTaP	1	01	12	2011
DTaP	2	03	20	2011
DTaP	3	06	01	2011

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

- 1) If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
- 2) If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
- 3) If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
- 4) If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: <http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm>

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Vaccine Trade Names in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)									
Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menaetra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqa	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrel)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)							
Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	<i>Haemophilus influenzae</i> type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

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