Class _____
Fee _____

Lynden Cooperative Preschool
Registration Form

Child's Name_____
Last First MI

Child's Birth Date _____ Age _____ Gender _____

Parent/ Guardian
Name _____
Address _____
_____
Phone _____
Cell _____
Work _____
Email _____

Parent/ Guardian
Name _____
Address _____
_____
Phone _____
Cell _____
Work _____
Email _____

Select one of the following levels of registration:

_____ Toddler Class (18-36mo old) *	$585 ÷ 9 months= ***$65 per month***
_____ Preschool (3-4 year old)	$945 ÷ 9 months= ***$105 per month***
_____ Pre-Kindergarten (4-5 year old)	$1,260 ÷ 9 months= ***$140 per month***

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

A $75 <u>non-refundable</u> Registration Fee must accompany application.
****Registration Fee for Toddler Class is $35****

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 last fee is assessed after the 5th. A $10 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 amounts.
6. As an affiliate of Whatcom Community College (WCC) parents are automatically enrolled in a 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
Parent Education Agreement

Child's Name _____ **Birth Date** _____

I wish to participate in the Lynden Cooperative Preschool (LCPS.) I have read and agree to the following:

1. I will enroll in the adult parent education class and pay the tuition required by WCC.
2. I will participate in the school as a teacher-parent as required. If I cannot participate, I will arrange for a substitute.
3. I will hold a board position or work job that has a time commitment average of 3.5 hours per month.
4. I will attend monthly parent education classes.
5. I will read and abide by the handbook, rules, and bylaws of the school. I understand that this requires me to participate in the operations of the school.
6. I will complete a health statement, immunization records and sign an emergency medical release form.
7. I will participate in fundraising activities.
8. I agree to pay tuition whether or not my child attends every day.
9. 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.
10. I agree to keep my child home if there are signs of a cold or other communicable diseases.
11. I will complete the required health and safety orientation.

Parent/ Guardian _____

Signature Printed Date

WCC encourages all custodial parents to participate in the cooperative experience.

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
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 partcipate in co-op activities during the school year?

_____

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.

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:	
Reviewed by:	Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No	

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

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

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

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

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for 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, DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / 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)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	_____
❑ Hepatitis B	❑ Rubella	_____
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name

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

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). 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, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: 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 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**.

#3 History of Varicella Disease: 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 healthcare 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 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS**.

Reference guide for vaccine abbreviations in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	*Haemophilus influenzae* type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade tames in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

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 (RV5)
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 December 2016

Washington State Department of Health

DOH 348-106 Jan 2015

Certificate of Exemption

SIDE A:
For Religious, Personal, Philosophical, and Medical Exemptions[1]

FOR OFFICE USE ONLY CHILD'S LAST NAME _____ FIRST NAME _____ M.I. _____

PART 1: PARENT OR GUARDIAN INSTRUCTIONS

In order for this form to be valid for religious, personal, philosophical, or medical reasons, please:

Step 1: Fill in your child's information in Boxes 1-4
Step 2: Read the Parent/Guardian Declaration
Step 3: Provide your initials where indicated
Step 4: Print your name, sign, and date in Boxes 5-6
Step 5: Have a provider complete Part 2 of this form

1. Child's Last Name

2. Child's First Name and Middle Initial

3. Birthdate (mm/dd/yyyy) _____/_____/_____

4. Gender
☐ Male
☐ Female

I am the parent or legal guardian of the above named child. One or more required vaccines are in conflict with my personal, philosophical, or religious beliefs.

Parent/Guardian Declaration

I understand that:

- *My child may not be allowed to attend school or child care during an outbreak of the disease that my child has not been fully vaccinated against.* _____ ***(initial)***
- *Exempting my child from any or all required vaccine(s) may result in serious illness, disability, or death to my child or others. I understand the risks and possible outcomes of my decision to exempt my child.* _____ ***(initial)***
- *The information provided on this form is complete and correct.* _____ ***(initial)***

5. Print Parent/Guardian Name

6. Parent/Guardian Signature and Date _____/_____/_____

PART 2: HEALTHCARE PROVIDER INSTRUCTIONS

In order for this form to be valid, please:

Step 1: Mark which disease(s) and what type of exemption is requested. If medical write a **T** for Temporary or **P** for Permanent.
Step 2: Discuss the benefits and risks of immunizations with the parent or guardian
Step 3: Read the Provider Declaration
Step 4: Print your name, credentials, sign, and date in Boxes 7-8

Vaccine	Personal/ Philosophical	Religious	Medical (T/P)**	Expiration Date for Temporary Medical
Diphtheria				
Hepatitis B				
Hib				
Measles				
Mumps				
Pertussis				
Pneumococcal				
Polio				
Rubella				
Tetanus				
Varicella				
All				

***A provider may grant a medical exemption only if there is a medical contraindication to a vaccine.*

Provider Declaration

I declare that:

- *I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child.*
- *I am a qualified MD, ND, DO, ARNP or PA licensed under Title 18 RCW.*
- *The information provided on this form is complete and correct.*

7. Print Provider Name and Credential **(MD, ND, DO, ARNP, PA)**

8. Provider Signature and Date _____/_____/_____

[1]RCW 28A.210.080-090 "Before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the State Board of Health, or (3) a certificate of exemption signed by a parent or guardian and is either A) signed by a licensed healthcare provider or B) demonstrates membership in a church or religious body that precludes healthcare practitioners from providing medical treatment to children."

Washington State Department of Health

Certificate of Exemption

SIDE B:
For Religious Membership Exemption ONLY

FOR OFFICE USE ONLY CHILD'S LAST NAME FIRST NAME M.I.

NOTICE: Complete this side if you belong to a church or religion that objects to the use of medical treatment.[1]

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, then you must use Side A of this Certificate of Exemption.

PARENT OR GUARDIAN INSTRUCTIONS

In order for this form to be legally valid for religious membership reasons, please:

Step 1: Fill in your child's information in Boxes 1-4
Step 2: Read the Parent/Guardian Declaration and provide your initials where indicated
Step 3: Provide the name of the church or religion of which you are a member, and print your name, sign, and date in Boxes 5-7

1. Child's Last Name

2. Child's First Name and Middle Initial

3. Birthdate (mm/dd/yyyy)
_____/_____/_____

4. Gender
☐ M ☐ F

I am the parent or legal guardian of the above named child and I am exempting my child from all required vaccinations.

Parent/Guardian Declaration

I understand that:

- *My child may not be allowed to attend school or child care during an outbreak of the disease that my child has not been fully vaccinated against.* _____ ***(initial)***
- *Exempting my child from all required vaccines may result in serious illness, disability, or death to my child or others. I understand the risks and possible outcomes of my decision to exempt my child.* _____ ***(initial)***
- *The information provided on this form is complete and correct.* _____ ***(initial)***

I affirm that I am a member of a church or religion whose teachings preclude healthcare practitioners from providing any medical treatment to my child.

5. Name of Church or Religion of Which You Are a Member

6. Print Parent/Guardian Name

7. Parent/Guardian Signature and Date
_____/_____/_____

[1]RCW 28A.210.090 "The parent of legal guardian demonstrates membership in a religious body or a church in which the religious beliefs or teachings of the church preclude a health care practitioner from providing medical treatment to the child."