ST. JOSEPH'S CATHOLIC SCHOOL

EXCELLENCE IN CATHOLIC EDUCATION

Preschool Only: Mark With **X**	AM = 5 days/week
	PM = 4 days/week Mon, Tues, Thurs. Fri

NEW Montessori Preschool – 8th Grade Student Registration Form 2018-2019

Grade Entering _____

Student ID#_____

(PLEASE PRINT)

Student's First Name_____Middle_____Last _____

Age_____ Male/Female Date of Birth_____Place of Birth _____

Religion_____ Parish _____

Sacraments received: Baptism _____ Eucharist _____ Confirmation _____

Applied for Financial Aid?_____ **Date Submitted:** _____

Student lives with: (X) Parents _____ Mother _____ Father _____ Guardian _____

☐ BLACK ☐ ASIAN ☐ WHITE ☐ HISPANIC ☐ AMERICAN INDIAN

(Optional, however this information is used for accurate National Catholic Education Assoc. and State Dept. of Education reports)

The racial/ethnic classifications and definitions are defined by the U.S. Department of Education, Office of Civil Rights. Other designations cannot be accepted. Each student should be identified using only one of the following five categories.

BLACK – Not of Hispanic Origin (A person having origins in any of the black racial groups.

ASIAN or **PACIFIC ISLANDER** – (A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example: China, Japan, Korea, the Philippine Islands, and Samoa)

AMERICAN INDIAN – (A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition)

HISPANIC – (A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race)

WHITE – (A person having origins in any of the original peoples of Europe, North Africa, or the Middle East)

Father/Guardian First: Last:	Mother/Guardian First: Last:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone: Cell:	Phone: Cell:
Email:	Email:
Religion:	Religion:
Parish/Church:	Parish/Church:
Occupation:	Occupation:
Employer:	Employer:

FOR OFFICE USE ONLY

☐ Registration Form Complete
☐ Registration Fee Paid SJS
☐ Smart Tuition Complete
☐ Financial Aid Application (if necessary)
☐ Immunization Current/Received
☐ Commitment Contract

ST. JOSEPH'S CATHOLIC SCHOOL

MEDICAL HISTORY FORM

Student Name _____ Age _____ Date of Birth _____

Mother's Telephone# _____ Mother's Cell# _____

Father's Telephone# _____ Father's Cell# _____

Parent/Guardian (*Please print*) _____

HISTORY

		YES	NO
1.	Is your student under a doctor's care now?		
2.	Are any medications or drugs being taken now?		
3.	Any Allergies to : Bee Stings		
	Asthma		
	Medications		
	Foods		
4.	Heart: Murmur of rheumatic fever?		
	Has anyone in the family, under the age of 50 died of heart disease?		
5.	Are there vision problems?		
	Glasses		
	Contact Lenses		
6.	Are there or have there been problems with:		
	Hearing		
	Kidneys		
	Testicles		
	Hernias		
7.	Has your child had any major medical illnesses?		
	Seizures		
	Diabetes		
	Arthritis		
8.	Have there been any operations or surgeries?		
9.	History of head trauma or repeated concussions?		
10.	Been in the hospital in the past year?		
11.	What was the date of last tetanus booster?		

Please explain any "Yes" answers on the above questions. Any further instructions or treatment required by the school personnel?

_____

_____

Signature of Parent/Guardian _____ Date _____

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 Guides 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 names 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	Fluceivax®	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).