Circle of Friends Preschool

Keep a spot for me

1/19

Child's Name		Placement # (Office Use)
Birthdate	Name your child goes by	Today's Date
Address		Zip
Parent/Guardian #1 Name	Parent/Guardian #2 Name	
Home Phone	Parent/Guardian #1 Cell	Parent/Guardian #2 Cell

*Enclose your nonrefundable registration check for $100.00 for the first child and $50.00 for each additional child, as well as the special events fee for field trips:
4 year-olds $10.00 and 4/5 year-olds $12.00.

Please number placement choice(s) in numerical order below.

Class Session	Class Time	Monthly Tuition	3 Year-olds *(By Aug. 31)*	4 Year-olds *(By Aug. 31)*	4 / 5 Year-olds *(By Dec. 31)*
Mon -Tues	9 - 11:30AM	$150			N/A
Mon -Tues	*12:30 - 3PM*	$150			N/A
Mon-Tues-Wed	9 - 11:30AM	$220	N/A		N/A
Mon-Tues-Wed	*12:30 - 3PM*	$220	N/A		N/A
Wed-Thurs-Fri	9 - 11:30AM	$220			N/A
Wed-Thurs-Fri	*12:30 - 3PM*	$220			N/A
Mon - Thurs	9 - 11:30AM	$260	N/A	N/A	
Mon - Thurs	*12:30 - 3PM*	$260	N/A	N/A	

Class Name: _____

Class Time: AM PM

Class Session: 2 Day 2 Day Plus 3 Day 4 Day

#

$

Office Use Only

Student Information Form

Child's Full Name _____ Birth date __/____/____

Name your child goes by _____ Gender: Male or Female

Parent/Guardian's Name _____ Relationship _____

Parent/Guardian's Name _____ Relationship _____

Child lives with:_____

Sibling Name _____ Age __ Sibling Name _____ Age __

Sibling Name _____ Age __ Sibling Name _____ Age __

Family Pets _____

We want your child to have a positive preschool experience. Please help us get to know them by sharing the following information.

1. A brief description of your child's personality: _____
2. Fears your child may have (dogs, sirens, etc.) _____
3. Any unusual experiences your child may have had (moving, hospital stay, loss of someone dear: _____
4. Your child's favorite toys or games: _____
5. Language spoken at home: _____
6. Which is your child's dominant hand? Right Left Undetermined
7. Type of previous group or preschool experience? Yes No Where? _____

Circle of Friends Preschool, 805 Columbia Ridge Drive, Vancouver, WA 98664
360-696-9926 cof@columbiapresbyterian.org www.cof-preschool.org

Dismissal & Emergency Contact Form

Child's Name: _____

Please list a minimum of two emergency contacts other than parents/guardians. We will make every effort to contact you in the event of an emergency. Should we not be able to get ahold of you, you authorize our staff to contact the following people.

You may also authorize people other than your child's parents/guardians to pick up your child from school. If someone not listed above is picking up your child, they must show their driver's license as identification, which should correspond with the note given to the teacher at the beginning of class. If the information is conflicting, the teacher is not to let the child go until proper confirmation has been made.

For each contact, check the appropriate boxes below. Your parent/guardian information is already on file.

In the event there is a medical emergency involving my child during the school hours at Circle of Friends Preschool, and I am unable to be contacted, I hereby give my permission for appropriate medical treatment to be given to my child by a licensed healthcare professional.

Dismissal Authorization and Emergencies Contacts	Does this person have permission to pick up your child?	Is this person an emergency contact?
Name_____ Phone (____) _____ Relationship_____	Yes No	Yes No
Name_____ Phone (____) _____ Relationship_____	Yes No	Yes No
Name_____ Phone (____) _____ Relationship_____	Yes No	Yes No
Name_____ Phone (____) _____ Relationship_____	Yes No	Yes No
Name_____ Phone (____) _____ Relationship_____	Yes No	Yes No

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Medical Release

I (We) the undersigned, parent or legal guardian of _____,

a minor, do hereby authorize and consent for Circle of Friends Preschool to seek medical treatment deemed necessary in the event of an emergency, accident or sudden illness. Every attempt will be made to immediately make contact with a parent.

I (We) will assume any expense incurred by such treatment.

Doctor preferred _____ Phone _____

Hospital preferred _____ Phone _____

Insurance Company _____ Policy Holder _____

Policy Number _____ Group Number _____

I (We) do not hold the above named, or Circle of Friends Preschool responsible or liable for any action necessary in the emergency care of my (our) child.

Signature _____ Date _____

Field Trip Participation Form and Liability Release

(Please complete this form if your child will be **4 or 5 years of age** on or before August 31st)

Special Events fees for field trips:

- ***$10 for Gumball and Lollipop (2 & 3 day) Students***
- ***$12 for Jellybeans (4 day) Students***

Name of Child _____

Address _____ Phone _____

- We, the undersigned and the parents or legal guardian(s) of the above named child do hereby give permission for participation in field trips and special events conducted away from the normal premises of this school.
- We are aware that transportation to and from these events will be provided by parents in the preschool program. Copies of currents drivers license and proof of insurance are necessary to transport. We are aware that the law requires that we must **provide a car seat for our child**.
- Being fully aware that this school will do everything in their ability to provide safety and assistance for my child. I will not hold this school (Circle of Friends Preschool), its board of directors (individually or jointly), director, teacher(s), or parent/volunteer(s) or Columbia Presbyterian Church-Vancouver responsible for any injury or physical hurt that may result from participation in such activities.

❖ **You will be notified in advance of each event. A signed permission slip is required so that your child may participate.**

Signature _____ Date _____

Food Allergy/Intolerance Statement

Name of Child _____ Birth date _____

1. Name of Parent/Guardian _____ Phone _____

2. Name of Parent/Guardian _____ Phone _____

We need to know the foods the child is allergic or intolerant to, as diagnosed by a physician, and the treatment steps to take in order to assist in treatment of an allergic reaction.

List each food separately	Food Intolerance	Food Allergy	Symptoms	Treatment (in order of action)
	Yes No	Yes No		1. 2. 3.
	Yes No	Yes No		1. 2. 3.
	Yes No	Yes No		1. 2. 3.
	Yes No	Yes No		1. 2. 3.

By signing below, I indicate my approval for Circle of Friends Preschool staff to assist in treatment of my child's immediate medical need.

Parent's Signature _____ Date _____

Parent's Name _____
(Please Print)

Do you consent to releasing your child's food allergy information to the other preschool classroom parents? Yes No

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Emergency Plan for Food Allergic Reactions

ALLERGY TO: _____

Student's Name: _____ D.O.B: _____

Asthma Yes* ☐ No ☐ *High Risk for severe reaction

SIGNS OF AN ALLERGIC REACTION

Systems:	**Symptoms:**
• **MOUTH**	itching & swelling of the lips, tongue, or mouth
• **THROAT**	itching and/or a sense of tightness in the throat, hoarseness and hacking cough
• **SKIN**	hives, itchy rash, and/or swelling about the face or extremities
• **GUT**	nausea, abdominal cramps, vomiting, and/or diarrhea
• **LUNG**	shortness of breath, repetitive coughing, and/or wheezing
• **HEART**	"thready" pulse, "passing-out"

The severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation.

ACTION FOR MINOR REACTION

If symptom(s) are: _____

☐ **Call: Parent/Guardian or Doctor**

☐ **Administer with Parental permission**: _____
Medication/dose/route

☐ **If condition does not improve within 10 minutes, follow steps for Severe Reaction below:**

ACTION FOR SEVERE REACTION

If symptom(s) are: _____

☐ **Administer:** _____ **IMMEDIATELY**!
Medication/dose/route

☐ **Call: 911 (Never hesitate to call 911)**

☐ **Call: Parent or Guardian**

Parent/Guardian _____ Phone # _____

Parent/Guardian _____ Phone # _____

Doctor _____ Phone # _____

Parent Signature: _____

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Additional Information

Church affiliation:	Denomination:
Who may we thank for your referral?	

Photo Release

Children will be photographed throughout the school year during the various activities. These pictures may be used in publications for Circle of Friends Preschool and/or Columbia Presbyterian Church, as well as the preschool website (no names listed) and slide shows throughout the school year. Please designate below if your child's picture may be used.

Private Facebook Page

This site is not open to the public and followers must request a private invitation to join. Activity reminders and parenting information is regularly posted, as well as teacher highlights.

Photos of ALL children will be used in Circle of Friends year-end slide show.	Publications & Website	Private Facebook Page
Child's Name _____ Parent/Guardian Signature _____ Date _____	Yes No	Yes No

Circle of Friends Preschool Registration

Student Information

Child's Full Name			Name your child goes by:
Date of Birth	Age	Gender	Today's Date

Parent/Guardian Information

Parent/Guardian		Phone ( )
Address	Zip	Cell ( )
Place of Employment		Work phone ( )
Parent/Guardian		Phone ( )
Address	Zip	Cell ( )
Place of Employment		Work Phone ( )

*Email address is for **school** communications only.*

***Home E-mail address*:**

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	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).

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