22-23 Washington School for the Deaf

Returning Student Packet

611 GRAND BLVD • VANCOUVER, WA 98661
P. 360-696-6525 • VP. 360-334-5448 • WSD.WA.GOV

Student Information

STUDENT INFORMATION

FIRST NAME | MIDDLE NAME | LAST NAME

ADDRESS | CITY | STATE | ZIP | COUNTY OF RESIDENCE

DATE OF BIRTH | PLACE OF BIRTH (CITY AND STATE OR COUNTRY) | GENDER | ETHNICITY

CURRENT GRADE | CURRENT SCHOOL DISTRICT

PARENT/GUARDIAN INFORMATION

FIRST NAME | MIDDLE NAME | LAST NAME

MAILING ADDRESS | CITY | STATE | ZIP

PHONE: (CIRCLE ONE) VOICE VIDEOPHONE **CELL PHONE:** (CIRCLE ONE) TEXT VOICE | EMAIL

OTHER PHONE | WORK PHONE | WORK EMAIL

FIRST NAME | MIDDLE NAME | LAST NAME

MAILING ADDRESS | CITY | STATE | ZIP

PHONE: (CIRCLE ONE) VOICE VIDEOPHONE **CELL PHONE:** (CIRCLE ONE) TEXT VOICE | EMAIL

OTHER PHONE | WORK PHONE | WORK EMAIL

EMERGENCY CONTACTS

FIRST AND LAST NAME | RELATIONSHIP | PHONE | PHONE

FIRST AND LAST NAME | RELATIONSHIP | PHONE | PHONE

FIRST AND LAST NAME | RELATIONSHIP | PHONE | PHONE

OTHER INFORMATION

WHAT IS THE PRIMARY LANGUAGE USED AT HOME? (PLEASE CIRCLE ONE)

ASL ENGLISH RUSSIAN SPANISH OTHER: _____

WHO HAS LEGAL CUSTODY OF THE CHILD? (PLEASE ATTACH COURT DOCUMENTS, IF NECESSARY)

DOES THE STUDENT HAVE VISUAL IMPAIRMENTS? YES OR NO (PLEASE CIRCLE)

IF YES, ARE THERE VISION SERVICES ON THE IEP? _____

DOES STUDENT HAVE VISION ISSUES THAT REQUIRE COORDINATION AND SERVICES WITH WASHINGTON STATE SCHOOL FOR THE BLIND? YES OR NO (PLEASE CIRCLE)

Student Directory Notice

Washington School for the Deaf (WSD) will disclose "directory information" about your student as provided for in law unless you expressly notify the school in writing that you do not wish for directory information to be disclosed. The primary purpose of directory information is to allow Washington School for the Deaf to include information from your child's education records in certain school publications. During the year, WSD utilizes communication materials to highlight the athletic and academic successes and recognize the achievements of WSD students and promoted the services of the school. Examples include, but are not limited to:

- WSD Website
- WSD Annual Yearbook
- Classroom videos
- Honor Roll or other recognition lists
- WSD Social Media (ie. Facebook, Instagram, YouTube, etc.)
- School Media (WSD related publications, news articles, deaf-related newsletters, etc.)
- Other Miscellaneous Publications (Playbills, Sports Programs)

WSD has designated the following information as directory information:

- Student's name, address, telephone number and age
- Participation in officially recognized activities and sports
- Height and weight of players on athletic teams
- Photographs & video footage
- Degrees, honors, and awards received
- Dates of attendance
- Grade Level

If you do not wish directory information to be released on your student, please make this request in writing within two weeks of receiving this notice.

Such request should be sent to:

Attention: Superintendent
Washington School for the Deaf
611 Grand Blvd.
Vancouver, WA 98661-4918

Directory information is information contained in the education records of a student that would not generally be considered harmful or an invasion of privacy if disclosed. Typically, "directory information" includes information such as name, address, telephone listing, date and place of birth, participation in officially recognized activities and sports, and dates of attendance. A school may disclose "directory information" to third parties without consent if it has given public notice of the types of information which it has designated as "directory information," the parent's or eligible student's right to restrict the disclosure of such information, and the period of time within which a parent or eligible student has to notify the school in writing that he or she does not want any or all of those types of information designated as "directory information." **34 CFR § 99.3 and 34 CFR § 99.37.**

Original: Academic CC: Residential

Media Release Form

During the school year, we take photographs/videos of school activities involving students to share the school's positive vibe and updates. By which incidentally, some photographs/videos may capture your students's participation, directly or indirectly. These photos/videos may be published through our website, social media pages, news bulletins, billboards, and ads. With this, we seek for your consent in allowing us to publish photos/videos which may involve your child to the said platforms.

As a parent/guardian of this student, I hereby consent to the use of photographs/videotape taken during the course of the school year for use in the following manners. I do this with full knowledge and consent and waive all claims for compensation for use, or for damages.

- ☐ WSD Website
- ☐ WSD Yearbook
- ☐ Classroom Videos
- ☐ Honor Roll or other recognition lists
- ☐ WSD Social Media (ie. Facebook, Instagram, YouTube)
- ☐ School Media (WSD related publications, newspapers, deaf-related newsletters, etc.)
- ☐ Other Miscellaneous Publications (Playbills, Sports Programs)
- ☐ All of the above

☐ No, I do NOT authorize Washington School for the Deaf (WSD) to photograph my student for any school purpose and/or school event.

Student Name: _____

Parent or Guardian Name: _____
Please Print

Parent or Guardian Signature: _____ Date: _____

Original: Academic CC: Residential

Internet Access Authorization

By signing this section, you are authorizing WSD to assign your child an internet account and password for personal use outside of the normal school hours. Internet authorization for residential/academic students provides them with an opportunity to complete school work requiring internet research outside of school hours. Please refer to the Parent/Student Handbook for school policies on student use of internet services.

Consequences of misuse of internet services may include temporary suspension of access to internet use.

Note: All students will have access to the internet under teacher supervision during classes that require internet research.

Parent or Guardian Name: _____
Please Print

Parent or Guardian Signature: _____ Date: _____

Original: Academic CC: Residential

1:1 Technology Responsible Use & Safety Agreement

PURPOSE: Washington School for the Deaf (WSD) may provide and assign students an iPad or laptop computer for use at school and at home as a means to promote achievement and provide flexible learning opportunities. This agreement provides guidelines and information about expectations for students and families who are being issued these one-to-one (1:1) devices. In addition to this agreement, the use of WSD technology also requires students to abide by the WSD Technology Use Guidelines as stated in the Student Code of Conduct. Additional rules may be added as necessary and will become a part of this agreement.

Our expectation is that students will responsibly use WSD technology and that they understand the appropriate and acceptable use of both the technology and WSD network resources. We also expect that students will make a good faith effort to keep their WSD-issued devices safe, secure and in good working order. This agreement includes the following specific responsibilities and restrictions.

RESPONSIBILITIES - The student will:

1. Charge their 1:1 device at home nightly, bringing it to school each day with a full charge.

2. Communicate Responsibly! Electronic communication should be conducted in a polite manner, using appropriate language and avoiding profanity and offensive or inflammatory speech. Cyber bullying, including personal attacks or threats toward anyone made while using WSD owned or personally owned technology, should be reported to responsible school personnel!

3. Back up important data files regularly to google. WSD may update and maintain 1:1 devices by periodically imaging them. Students will be notified of this maintenance in advance when possible, however all student files should be saved to online storage space regularly to ensure data is not lost when maintenance is required. Ask for assistance if you do not know how to back-up files.

4. Use technology for school-related purposes during WSD day and after school. Use for commercial or political purposes is prohibited.

5. Zoom is for Staff to student communication only. You must use your real name or you will be removed from the class and marked as absent. No video or chat with people outside of the school. No personal zoom accounts on iPads. Only school accounts allowed.

6. Students must use school google accounts only. No personal accounts allowed on school devices.

7. Follow copyright laws and fair use guidelines and only download/save music, video or other content that are related to specific assignments. WSD technology is not provided to house personal music or video libraries

8. Make the 1:1 device available for inspection by any administrator, teacher or parent upon request. All electronic communication, activities and files accessed on WSD technology are not private and may be viewed, monitored or archived by the WSD at any time.

9. All iPads and personal devices connected to our wifi are filtered to the best of our ability. Any student that has a personal device connected to a personal hotspot is not monitored by us and it is up to the students guardians to determine if websites are appropriate for student use after school hours.

Despite these restrictions, students sometimes choose to tamper with the security and software settings on their devices in order to get around various restrictions. In addition to the workload placed on WSD staff to restore these devices, this misbehavior directly impacts student learning, as students who tamper with their devices are often unable to do assigned classwork both in the classroom and at home. **As a result, a fee will be assessed to a student who has willfully tampered with the security settings or restrictions on any 1:1 device per incident.**

In addition to the specific requirements and restrictions detailed above, it is expected that students and families will apply common sense to the care and maintenance of WSD-provided 1:1 technology. In order to keep iPads and laptops secure and damage free, please do not loan your 1:1 device or charger and cords to anyone else, leave the 1:1 device in a vehicle or leave it unattended at any time, or eat/drink while using the 1:1 device.

Devices accidentally broken will be replaced without charge up to the third break. After that time families will be responsible to pay for damages as determined by the type of damage up to a total replacement of $450.00
Replacement cost for lost cords and bricks is $25.00. Replacement cost for broken cords and bricks are free if they bring them back to trade.

CONTINUED ON NEXT PAGE

1:1 Technology Responsible Use & Safety Agreement Cont.

Parent/Guardian Monitoring Responsibility:

Even with our filtering measures in place, parents and/or guardians assume responsibility for monitoring their child's activity on school-issued devices and accounts during non-school hours and on non-student attendance days. Users are responsible for the appropriate use of the device and all accounts, applications, and services.

If information is collected that indicates activity outside of the acceptable use, that information will be reviewed with the student and/or parent/guardian during normal school business hours.

IMPORTANT SAFETY NOTE: Information obtained by school personnel, after school business hours suggesting or indicating immediate danger to a person(s) will initiate a 911 report upon receiving that information. Administration will contact the parent/guardian on the next school business day regarding the matter.

WSD is not responsible for any loss resulting from use of WSD-issued technology and makes no guarantees that the technology or the WSD network systems that support student use will be available at all times. By signing this agreement you agree to abide by the conditions listed above and assume responsibility for the care and proper use of WSD WSD-issued technology. You understand that should you fail to honor all the terms of this agreement, access to 1:1 technology, the Internet, and other electronic media may be denied in the future. Furthermore, students may be subject to disciplinary action outlined in the WSD Student Code of Conduct.

As the parent/guardian, my signature indicates I have read and understand this Responsible Use and Safety Agreement, including the tampering fee, and for full replacement if there is intentional breakage. I give my permission for my child to have access to and use WSD-issued technology.

Parent or Guardian Name: _____
Please Print

Parent or Guardian Signature: _____ Date: _____

As the student, my signature indicates I have read or had explained to me and understand this Required Use and Safety Agreement, including the tampering fee, and for full replacement if there is intentional breakage. I accept responsibility for abiding by the terms and conditions outlined and using these resources for educational purposes.

Student Name: _____ Grade: _____
Please Print

Student Signature: _____ Date: _____

Original: Library CC: Academic

RESIDENTIAL STUDENTS ONLY

Personal Accounts

The Washington School for the Deaf cannot loan money to students for personal needs, school sponsored events, allowance, etc. If your child is a residential student and you would like to make funds available to your child, the Business Office will set up a student personal account from which the child may request money.

The request for money is considered the child's "allowance" and is distributed every Wednesday via the Student Life Counselors. All requests must be received by Monday for Wednesday's allowance.

The Business Office will not determine restrictions on student personal accounts. To place restrictions on your child's personal account, complete the following section and mail it with your student packet. *If the following section is not returned, a NO RESTRICTION will be put on your child's account.*

Please return this form with completed Admissions Packet

Amount of weekly allowance student may have: $_____

Total amount deposited: $_____

Student Name: _____

Parent or Guardian Signature: _____ Date: _____

Please make all checks and/or cashiers checks payable to: "**WSD**"
For depositing purposes, please write the name of your student in the memo section of the check.

Original: Business Office CC: Residential

Medicaid Eligibility Verification

PURPOSE

This form asks for your consent to obtain information from the Department of Social and Health Services, Medical Assistance. Administration for the purpose of Medicaid eligibility verification. If you have questions regarding this request, you may call the WSD Special Education Secretary at 360-334-5449 (VP) for an explanation as to why the request is being made.

MEDICAID ELIGIBILITY VERIFICATION

State law requires the school district to submit claims for health-related services provided to special education students or students referred for special education. These services include physical therapy, speech-language therapy, audiology, nursing, counseling, and psychological evaluation.

With your permission, we will submit your student's name and birth date to the Department of Social and Health Services (DSHS) to verify Medicaid eligibility. Such a request will in no way negatively impact services included in your child's individualized education program (IEP).

□ I **do** give consent to verify Medicaid eligibility with DSHS.

□ I **do not** give consent to verify Medicaid eligibility with DSHS.

Student Name: _____ Date of Birth: _____
Please Print

Parent or Guardian Name: _____
Please Print

Parent or Guardian Signature: _____ Date: _____

Original: SES

Consent to be Interviewed by DCYF

Dear Parent/Guardians:

The Washington School for the Deaf is collaborating with the Department of Children, Youth and Families (DCYF) to ensure all students are safe while at WSD. In order to gather information, DCYF interviews students and parents using a certified interpreter when needed. This is a great opportunity for you and your student to be involved in supporting WSD. Your involvement is valuable. Below are sample DCYF Questions for both parents and students.

Please sign the bottom of this consent if you give permission for DCYF to interview you and/or your child and thank you for your help.

SAMPLE DCYF STUDENT QUESTIONS

- How long have you been going to school at WSD?
- Do you have a teacher or staff person you feel comfortable sharing your feelings with?
- Has this person ever helped you solve or work with your problems or concerns?
- Is it easy for you to contact your parents while you are at school? Are there rules that tell you when you cannot call your parents?
- What happens if someone breaks a safety rule?
- Are there fire drills at school and in the cottages?
- Have any staff or students ever made you feel uncomfortable or made physical or verbal threats toward you? If so, did you tell one of the staff about it?
- Do you feel safe here? Do you think other students are safe here?

SAMPLE DCYF PARENT QUESTIONS

- How long has your child lived at the School for the Deaf? (residential program)
- What is your general impression on the level of care your child is receiving in the residential program?
- Do you have any health and safety concerns about the residential program at the School for the Deaf?
- Do you think your child or other children in the facility receive adequate supervision while living in the residential program and the School for the Deaf? If no, what are your concerns?
- Do you feel that the residential program at the School for the Deaf keeps you informed on what's happening with your child?

☐ I give permission for my child, _____ , to be interviewed by the DCYF.

☐ I am willing to be interviewed by the Department of Children, Youth & Families (DCYF)

Parent or Guardian Name: _____
Please Print

Parent or Guardian Signature: _____ Date: _____

Original: Residential

Consent to Leave Campus

Please draw a line across form and sign on signature line for NON CONSENT to leave campus with anyone other than parent/guardian.

Student Name: _____
Please Print

The above named student has permission to leave campus for outings and/or overnight or weekend visits with the following friends and/or relatives:

Friend/Relative #1

Name: _____ Relationship to student: _____
Please Print

Address: _____ Phone Number: _____

Friend/Relative #2

Name: _____ Relationship to student: _____
Please Print

Address: _____ Phone Number: _____

Friend/Relative #3

Name: _____ Relationship to student: _____
Please Print

Address: _____ Phone Number: _____

Friend/Relative #4

Name: _____ Relationship to student: _____
Please Print

Address: _____ Phone Number: _____

I understand that WSD has no responsibilities or liabilities for my child when my child leaves campus with any of the above named.

RESTRICTED VISITATION:

The following person(s) does not have my permission to visit or take my child off campus.

Name: _____ Relationship to student: _____
Please Print

Address: _____ Phone Number: _____

Note: Use additional paper, if necessary, to explain. WSD must have a court order on file for any restraining orders.

Parent or Guardian Name: _____
Please Print

Parent or Guardian Signature: _____ Date: _____

Original: Academic CC: Residential CC: SHC

WSD Field Trip Authorization

WSD academic and residential staff plan off-campus outings for students throughout the year. WSD staff accompanies the students on these off-campus outings and the students are supervised according to their individual supervision needs. Students and staff will walk, use public transportation or use state vehicles. Activities or educational outings will be planned at a variety of local locations. These locations may include but are not limited to the following:

Parks: Ape Caves, Ft. Vancouver, Esther Short, Marshall Center, Marshall Park, Hazel Dell, Wintler, Battle Ground, Vancouver Lake, Klineline Pond, LaCamas Lake, Water Resource Center

Community Educational Resources: Chestnut Lane Assisted Living (Gresham, Oregon), Fort Vancouver, Clark County Museum, Ft. Vancouver Library, Fort Vancouver Historical Area, Harney Elementary School, Oregon Children's Theater Productions (Keller Auditorium, Winningstad Theater, and/or Newmark Theater), Oregon Historical Society, Oregon Museum of Science and Industry (OMSI), Oregon School for the Deaf, Oregon Zoo, Portland Art Museum, Powell's Book Store (Portland), Recycling Center, World Forestry Center (Portland)

Restaurants: Oyako, Cold Stone Creamery, Subway, Taco Time, McDonald's, Taco Bell, Dairy Queen, Jack-in-the-Box, Burger King, Wendy's, Baskin Robbins, Papa Murphys, Burgerville, Paper Tiger, Muchas Gracias, Blind Onion, Starbucks, Black Rock, Panda Express, Red Robin, Freshii, Ginger Pop

Banks: IQ Credit Union, Chase, Bank of America, Wells Fargo, First Independent, Today's Bank, Columbia Credit Union

Fun in the Community: Family Fun Center Amusement Park, Clackamas Water Park, Downtown Vancouver, Firstenburg Center, Fred Meyer, Crosley Lanes, Jim Parsley Recreation Center, Kid's Club in Salmon Creek, Marshall Community Center (pool), Mountain View Ice Arena, Oaks Park, Regal Cinemas, SWCDHH, Vancouver Mall, Washington State School for the Blind, Vancouver Waterfront

A reminder note of an upcoming field trip will be sent home prior to the actual field trip, giving you the specific details.
By signing below you give permission for your child to participate in academic/residential upcoming events throughout the entire school year. Should you NOT want your child to attend a certain event, please notify the School Secretary at:

Elementary:
VP: (360) 334-5449 | Email: jackie.valadao@cdhy.wa.gov

Secondary:
VP: (360) 334-5618 | Email: rima.nandakumar@cdhy.wa.gov
or
Your child's Student Life Counselor.

Please sign and return this form so your child may participate in off campus activities.

Money for activities/outings may be: ☐ **Sent from home** ☐ **Taken from students account**

Parent or Guardian Name: _____
Please Print

Parent or Guardian Signature: _____ Date: _____

Original: Academic CC: Residential

RESIDENTIAL STUDENTS ONLY

Transportation Authorization

Student Name: _____ Students Flight City or Bus Stop: _____
Please Print

All students under the age of 18 must be supervised by an adult until the student boards WSD provided transportation. Minor children may not wait at the airport/bus stop unattended. Parents/Guardians are responsible for meeting the plane/bus at the designated gate/stop at the scheduled time of arrival. Parents/Guardians may designate another adult to drop off/pick up their child.

I authorize the following adult individuals to pick up my child:

_____
NAME RELATIONSHIP TO STUDENT PHONE NUMBER: VOICE TEXT VP (Please circle one)

_____
NAME RELATIONSHIP TO STUDENT PHONE NUMBER: VOICE TEXT VP (Please circle one)

_____
NAME RELATIONSHIP TO STUDENT PHONE NUMBER: VOICE TEXT VP (Please circle one)

_____
NAME RELATIONSHIP TO STUDENT PHONE NUMBER: VOICE TEXT VP (Please circle one)

I **will not allow** the following person(s) to pick up my child:

_____

No child under the age of 18 will be left alone at a gate/stop.

FOR THE SAFETY OF STUDENTS, PARENTS WILL BE ASKED TO SIGN A RELEASE AT THE TIME OF PICK UP. PLEASE APPROACH THE TRANSPORTATION MONITOR/AIRLINE REPRESENTATIVE TO SIGN OUT YOUR CHILD. BE PREPARED TO SHOW IDENTIFICATION.

I understand that I may choose one flight/bus stop. I understand the Washington School for the Deaf will transport my child from/to Vancouver, Washington only to the stated above designated city/stop on weekend travel dates. (Please refer to school calendar for specific travel dates).
I understand that WSD will not alter this destination without prior approval from the Transportation Secretary or Superintendent's office. WSD only transports students on their regularly scheduled plane/bus. If my child is not traveling on WSD's provided plane/bus, I must fill out a Release Form and submit it to the Transportation Secretary by TUESDAY AT 5:00 PM. I understand I will have to provide my child's transportation and pay for the cost.

By signing this AUTHORIZATION, I acknowledge I have read,understand and agree with its contents and I am responsible for meeting my child on time.

Parent or Guardian Signature: _____ Date: _____

Phone Number: _____ VOICE TEXT VP (Please circle one)

Phone Number: _____ VOICE TEXT VP (Please circle one)

Email: _____

Original: Residential

DAY STUDENTS ONLY

STUDENT TRANSPORTATION REQUEST AND INFORMATION

ESD 112 SPECIALIZED TRANSPORTATION (360)750-7510 TOLL FREE (800) 233-4883 FAX(360)694-5638

PLEASE FILL THIS FORM OUT COMPLETELY

Student:

Pick-up Address:

Drop-off Address (if different from Pick-up)

School Year 20_____ or ESY 20_____ M / F

DOB(*Required*)_____ Grade:_____

Parent/Guardian

Mailing Address

City/State: Zip

Home Phone: Cell Phone:

Wk Phone: Other Ph:

Resident District:

Request Made by:

Signature:

Superintendent/Designee

Print Name and Title:

Phone: Date:

Transport To:

Street Address:

Contact & Ph #:

Start Date: End Date:

Start Time: End Time:

Days of Week (circle) M T W Th F

ALTERNATIVE HOME/LOCATION TO TAKE STUDENT TO IN CASE OF EMERGENCY:

All students transported by ESD112 Specialized Transportation program MUST BE MET by a pre-authorized parent/guardian/teacher. If a student is to be left at home/school without adult supervision, resident district MUST authorize and note that instruction in the provided field below. All authorized adults receiving this student must be noted on this form.

ALTERNATIVE NAME:

Address:

City/State/Zip:

Phone:

AUTHORIZED TO RECEIVE STUDENT:

STUDENT IS AUTHORIZED TO BE LEFT AT HOME/SCHOOL WITHOUT ADULT SUPERVISION: YES____ NO____

Transportation is a *"RELATED SERVICE"* Per IEP: YES _____NO_____ Per 504: YES_____NO_____

Handicapping Condition:

Communicates: Voice_____ Sign_____ Other_____

Ambulatory: Yes_____ No_____

Medical Protocol for School Bus Transport:_____

SPECIAL EQUIPMENT NEEDS: None____Wheelchair____Walker____Carseat/CSRS____Other____(list below)

Attention/Comments (i.e. allergies, diabetes,seizure,behavioral issues, special circumstances, etc):

Dear Parent/Guardian,

The student Health Record gives permission to provide medical care for your student. It also helps the nurse better understand your student's needs and the parent/guardian wishes as it relates to your students medical care. Please completely fill out, sign, date, and return this form as soon as you can so we can provide your student with a higher level care.

Thank you, and please contact the Student Health Center (SHC) if you have any questions or concerns.

WSD Student Health Center
Office: (360) 418-4333
Cell: (360) 597-8223
Fax: (360) 418-4383
VP: (360) 335-5791
Email: nurses@cdhy.wa.gov

REQUIRED:

The Student Health Packet forms are required to be filled out completely in order to attend Washington School for the Deaf

Student Health Record

Student Name: _____ Sex: _____ DOB: _____
Please Print

Medical Permission	Yes	No	Restrictions and/or Comments
Local/community providers (physicians, nurse practitioners, and physician assistants) and providers contracted/employed by WSD may provide Urgent/Emergency medical care as needed. (Non-urgent care should continue at home)			
My child's physicians/providers may be contacted as needed.			
I give permission for WSD staff to act on my behalf when making emergency medical decisions, should I be unavailable in an emergency.			
WSD nurses and delegated staff may administer prescription medications, over the counter medications and treatments prescribed by a licensed provider. Please note any medications or treatments that should not be given related to allergies or health conditions.			
Nurses may convey confidential medical information, only as they perceive beneficial to the health and safety of the student, to staff working with my child.			
Nurses may give my child his/her medication to bring home for the weekend or vacation in the event no staff is available to transport it.			
I will share my e-mail in hopes that the nurses keep in weekly contact with me regarding the refill of my student's medication(s).			EMAIL: _____
Nurses may leave a message containing information regarding my child's health condition at the following numbers:			PHONE: _____ PLEASE CIRCLE ONE: VIDEOPHONE VOICE TEXT

Medical History	Parent Comments
Please note any health condition(s) that are life threatening (asthma, seizures, diabetes, allergies, etc.) Health Conditions that are Life Threatening: Any condition that is life threatening, according to RCW 28A.210 Sec. I requires that a nursing plan/ECP be in place before the student attends school.	
Please list any/all allergies to medications, foods, environmental or insect stings.	
Special Instructions/Care Needs. Please list if your child has any adaptive devices such as cochlear implants, hearing aids, retainers, glasses, special orthodontics or any devices your child may use.	
Please list all acute/chronic medical conditions and concerns.	
Special Diet for any medical reasons (must be accompanied by a signed provider dietary order) or religious reasons.	
Activity Restrictions/Modifications (must have signed provider order).	

I am responsible for providing payment or medical insurance coverage for my student including medical expenses, evacuation and/or emergency transportation charges. Washington School for the Deaf does not provide medical insurance coverage for students and will not be held responsible for medical expenses under any circumstance. Note: We would appreciate your bringing medical card so we can make a copy during registration.

Parent or Guardian Signature: _____ Date: _____

RESIDENTIAL STUDENTS ONLY

Copy of Medical Insurance Card

Student Name: _____ DOB: _____
Please Print

INSURANCE INFORMATION
Name & Address of Insurance Company:
Policy & Group Numbers/Union & Local:

Authorization for Medications & Treatments at School

Student Name: _____ DOB: _____
Please Print

ATTENTION PARENTS:

If your student needs to take medications at school, **this form needs to be signed by your doctor** and on file at

We appreciate the name of your students physician if they receive medication from you during the year.

PHYSICIAN/PRIMARY CARE PROVIDER INFORMATION:

Physician's Name: _____ Clinic Name: _____
Please Print

Address: _____

Phone Number: _____ Fax Number: _____

MEDICATION	DOSAGE	ROUTE	TIMES PER DAY	REASON FOR MEDICATION

Diet Restriction(s): _____

Activity Restriction(s): _____

Can student self-carry medications? ☐ **Yes** ☐ **No**

Can student self-administer medications (including inhalers)? ☐ **Yes** ☐ **No**

Provider (physician, nurse practitioner, or physician assistant) signature required for WSD Nurses to administer prescription and over-the-counter medication(s), for WSD food service to offer special diet plan, and/or WSD staff to ensure activity restrictions.

Physician Signature: _____ Date: _____

WSD Physician Signature: _____ Date: _____

Request for Meal Modification

Request for meal modification must be signed by a State-Recognized Medical Authority, a licensed health-care professional authorized to write medical prescriptions in Washington. *Also acceptable is a doctor's note answering the questions on this form.

What is considered a meal modification?
Food(s) to be substituted; Food(s) to be omitted/avoided from the child's diet

What is considered a milk replacement?
Lactose free milk &/or soy milk

Student Name: _____ DOB: _____ Grade: _____
Please Print

Mailing Address: _____

Phone Number: _____ Email: _____

Parent or Guardian Name: _____
Please Print

Parent or Guardian Signature: _____ Date: _____

State-Recognized Medical Authority must complete and sign this section.

1. Describe how the impairment affects the child (i.e., how the ingestion/contact with the food impacts the child):

2. Explain what must be done to accommodate the child's diet (i.e., specific food(s) to be omitted/avoided from the child's diet):

3. List food(s) and/or beverages to be substituted, provided, or modified:

Signature of State-Recognized Medical Authority: _____

Date: _____

Certificate of Immunization Status (CIS)

Washington State Department of Health

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	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	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)						
COVID-19						
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 Pediarix 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).

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