

For Office Use:

Classroom: \_\_\_\_\_

MWF or TuTh

AM or PM

Pullman Parks & Recreation Preschool

# Annual Information Update 2018-2019

Please Print Clearly

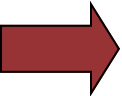
Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please give the e-mail address you would like the monthly Preschool Newsletter and calendar sent to:



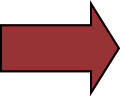
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Other Languages Spoken in the Home: \_\_\_\_\_

Mother's Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father's Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_



Would you like to receive SMI Alerts from Parks & Recreation Yes No Carrier \_\_\_\_\_

Emergency contact person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

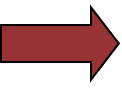
Special Concerns: \_\_\_\_\_

\_\_\_\_\_

Date last seen by a doctor/last physical exam: \_\_\_\_\_

Medical Concerns or other fears/phobias, etc: \_\_\_\_\_

\_\_\_\_\_



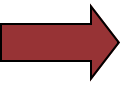
Allergies: \_\_\_\_\_

New sister or brother? \_\_\_\_\_

New family living arrangements? \_\_\_\_\_

Specify custody arrangements: \_\_\_\_\_

\_\_\_\_\_



Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**You will need to fill out an updated Certificate of Immunization—this should include any vaccinations received prior to September 2018.**

Pullman Parks & Recreation Preschool  
**Emergency Information Form 2018-2019**

**Please Print Clearly**

Date: \_\_\_\_\_

Child's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_

**In case of emergency when parents/guardian can't be reached, please notify:**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Child's doctor \_\_\_\_\_ Phone \_\_\_\_\_

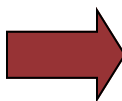
List all allergies \_\_\_\_\_

**Emergency Medical Treatment Procedure**

In the event of an emergency, whenever possible, parents or persons listed above will be notified and asked to take their child to their family physician for medical treatment. If no parent or guardian can be reached, we will call 911 to have the child transported by ambulance to the local hospital.

I, the undersigned, in consideration of your accepting \_\_\_\_\_ (child's name), hereby assume all risk and hazards of the conduct of this preschool program and release all claims and rights for damages my child may have against the City of Pullman, its employees, or agencies co-sponsoring this program. I also acknowledge for my child that the City of Pullman provides no medical coverage of any kind for any accident or injuries that might result in participation in city sponsored programs.

In the event that my child is injured or should require medical attention, I hereby authorize Pullman Parks and Recreation to secure necessary medical treatment. Confirmation of this authorization should be made with me prior to treatment by calling me at the above listed phone number. In case I cannot be reached for an emergency, medical treatment as described above may proceed without further authorization.



Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Pullman Parks & Recreation Preschool Release Form 2018-2019

**This list should include all parent/guardians, grandparents, and friends that you authorize to pick up your child from Pullman Parks & Recreation Preschool. Your child will not be released to someone not listed below. You may update this list anytime during the school year.**

Please Print Clearly

Date: \_\_\_\_\_

The following people are authorized to pick up \_\_\_\_\_  
(Child's First and Last Name)

\_\_\_\_\_  
Name: Parent/Guardian Mother Father Guardian \_\_\_\_\_  
Phone

\_\_\_\_\_  
Name: Parent/Guardian Mother Father Guardian \_\_\_\_\_  
Phone

\_\_\_\_\_  
Name: Friend Relative Other/Sitter \_\_\_\_\_  
Phone

\_\_\_\_\_  
Name: Friend Relative Other/Sitter \_\_\_\_\_  
Phone

\_\_\_\_\_  
Name: Friend Relative Other/Sitter \_\_\_\_\_  
Phone

\_\_\_\_\_  
Name: Friend Relative Other/Sitter \_\_\_\_\_  
Phone

\_\_\_\_\_  
Name: Friend Relative Other/Sitter \_\_\_\_\_  
Phone

\_\_\_\_\_  
Name: Friend Relative Other/Sitter \_\_\_\_\_  
Phone

\_\_\_\_\_  
Name: Friend Relative Other/Sitter \_\_\_\_\_  
Phone

 \_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**If you cannot be reached at home or work, please provide a schedule detailing where you will normally be during your child's preschool schedule.**

\_\_\_\_\_  
Location

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Location

\_\_\_\_\_  
Phone

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Pullman Parks & Recreation Preschool  
**Parental Permission for  
Preschool Field Trips 2018-2019**

The undersigned, hereby give my child \_\_\_\_\_  
permission to participate in Pullman Parks & Recreation Preschool field trips  
taken during the 2018-2019 preschool year. (Including but not limited to: walks  
and or bus rides to the city parks, Neill Public Library, Police Station, Fire Station,  
and local businesses). I will not hold the City of Pullman or any of those  
participating and/or supervising in the activity, responsible for any injury incurring  
during or en-route to the activity.



\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone



# Certificate of Immunization Status (CIS)

For Kindergarten-12<sup>th</sup> Grade / Child Care Entry

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.**

<b>Child's Last Name:</b> _____	<b>First Name:</b> _____	<b>Middle Initial:</b> _____	<b>Birthdate (MM/DD/YY):</b> _____	<b>Sex:</b> _____
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.		I certify that the information provided on this form is correct and verifiable.		
<b>Parent/Guardian Signature Required</b> _____		<b>Parent/Guardian Signature Required</b> _____		
<b>Date</b> _____		<b>Date</b> _____		

	Date	Date	Date	Date	Date	Date
◆ Required for School and Child Care/Preschool	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
● Required Only for Child Care/Preschool	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
<b>Required Vaccines for School or Child Care Entry</b>						
◆ <b>DTaP / DT</b> (Diphtheria, Tetanus, Pertussis)						
◆ <b>Tdap</b> (Tetanus, Diphtheria, Pertussis)						
◆ <b>Td</b> (Tetanus, Diphtheria)						
◆ <b>Hepatitis B</b>						
<input type="checkbox"/> 2-dose schedule used between ages 11-15						
● <b>Hib</b> ( <i>Haemophilus influenzae</i> type b)						
◆ <b>IPV / OPV</b> (Polio)						
◆ <b>MMR</b> (Measles, Mumps, Rubella)						
● <b>PCV / PPSV</b> (Pneumococcal)						
◆ <b>Varicella</b> (Chickenpox)						
<input type="checkbox"/> History of disease verified by IIS						
<b>Recommended Vaccines (Not Required for School or Child Care Entry)</b>						
<b>Flu</b> (Influenza)						
<b>Hepatitis A</b>						
<b>HPV</b> (Human Papillomavirus)						
<b>MCV / MPSV</b> (Meningococcal)						
<b>MenB</b> (Meningococcal)						
<b>Rotavirus</b>						

**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.**

<input type="checkbox"/> Diphtheria <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hib <input type="checkbox"/> Measles	<input type="checkbox"/> Mumps <input type="checkbox"/> Polio <input type="checkbox"/> Rubella <input type="checkbox"/> Tetanus <input type="checkbox"/> Varicella <input type="checkbox"/> Other: _____
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Licensed healthcare provider signature \_\_\_\_\_ Date \_\_\_\_\_  
(MD, DO, ND, PA, ARNP)

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: [waisrecords@doh.wa.gov](mailto:waisrecords@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/completeistofvaccinenames.pdf>

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus, Pertussis	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	<i>Haemophilus influenzae</i> type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine				
Flu (IV)	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/completeistofvaccinenames.pdf>

Trade Name	Vaccine	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	Twintrix®	Hep A + Hep B		
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnam®	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).