# KINDERGARTEN REGISTRATION CHECKLIST

## INCOMPLETE FILES WILL DELAY STUDENT PLACEMENT

## Please check off when you have filled out each of the following forms, then sign below.

☐ Student Registration
☐ General Health History
☐ Student Health Information
☐ Certificate of Immunization Status Form (Immunization Form)
☐ Kindergarten-Development Background
☐ Home Language Survey

Signed_________________________________

The following documents will also be required to complete your registration:

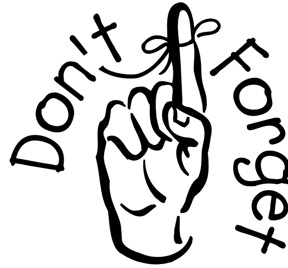
☐ **Original Birth Certificate** – May be obtained from the Skagit County Health Department at the Administration Building on 2nd and Kincaid in Mount Vernon. (336-9380) _________
***Roundup Staff Initials***

☐ **Copy of child's immunization record** _________
***Roundup Staff Initials***

Completed packets may be submitted to the following locations:

| | |
|---|---|
| April 23 and April 24 | Kindergarten Round-up |
| April 27 – September 1 | Whitney School Office – 1200 M. Avenue |

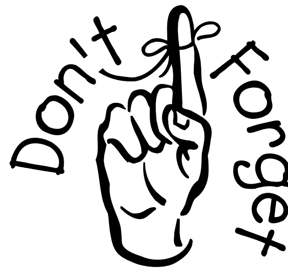
# Anacortes School District




If you have not presented an official birth certificate (not a copy) at Kindergarten Round-Up, the certificate must be brought to the Whitney School office by May 31st.

Classroom assignments will be made only for students with complete registration records.

# Anacortes School District




If you have not presented an official birth certificate (not a copy) at Kindergarten Round-Up, the certificate must be brought to the Whitney School office by May 31st.

Classroom assignments will be made only for students with complete registration records.

DATE____________________

# NEW STUDENT REGISTRATION FORM

| DO NOT WRITE IN SHADED AREA – FOR OFFICE USE ONLY | | | | | |
|---|---|---|---|---|---|
| STUDENT SCHOOL NUMBER | SCHOOL ENTRY DATE | MEDICAL ALERT | PREVIOUSLY ATTENDED ASD? | DATES OF ATTENDANCE: | BUS ROUTE<br>AM PM |

| STUDENT NAME: Legal Last Name | Legal First Name | Legal Middle Name | Also known as: |
|---|---|---|---|
| BIRTHDATE (Month/Day/Year) | GENDER (M/F) | BIRTHPLACE: City State Country | GRADE LEVEL |

| STUDENT SOCIAL SECURITY # (optional) | ETHNIC CODE (Check One) | PRIMARY LANGUAGE SPOKEN AT HOME | US CITIZEN |
|---|---|---|---|
| | ☐ A-Asian or Pacific Islander ☐ I-American Indian or Alaska Native<br>☐ B-Black, not of Hispanic origin ☐ W-White, not of Hispanic origin<br>☐ H-Hispanic | ☐ English ☐ Spanish<br>☐ Other ____________________________ | ☐ Yes ☐ No |

| PRIMARY HOUSEHOLD (parent/guardian where student resides)<br>*Last Name* *First Name* | STUDENT LIVES WITH | PHONE #1 - Home Phone (include area code) | PHONE ☐ Work ☐ Cell (include area code) |
|---|---|---|---|
| (parent/guardian where student resides)<br>*Last Name* *First Name* | ☐ Both parents<br>☐ Father only<br>☐ Mother only<br>☐ Grandparents<br>☐ Father/Stepmother<br>☐ Mother/Stepfather<br>☐ Stepfather/Stepmother<br>☐ Guardian ☐ Agency<br>☐ Self ☐ Other _________ | Please check if unlisted ☐ | PHONE ☐ Work ☐ Cell (include area code) |

| RESIDENT ADDRESS | *Street* | *Apt #* | | *City* *State* *ZIP* |
|---|---|---|---|---|
| MAILING ADDRESS (If different from above) | *Street* | *Apt #* | *P O Box* | *City* *State* *ZIP* |

| SECOND HOUSEHOLD (non-custodial parent not residing with student)<br>*Last Name* *First Name* | RELATIONSHIP | PHONE #1 (include area code)<br>☐ Home ☐ Work ☐ Cell | PHONE (include area code)<br>☐ Home ☐ Work ☐ Cell |
|---|---|---|---|
| (non-custodial parent not residing with student)<br>*Last Name* *First Name* | ☐ Both parents<br>☐ Father only<br>☐ Mother only<br>☐ Grandparents<br>☐ Father/Stepmother<br>☐ Mother/Stepfather<br>☐ Stepfather/Stepmother<br>☐ Guardian ☐ Agency<br>☐ Self ☐ Other _________ | PHONE #1 (include area code)<br>☐ Home ☐ Work ☐ Cell | PHONE (include area code)<br>☐ Home ☐ Work ☐ Cell |
| SECOND HOUSEHOLD ADDRESS *(Street/PO Box, City, State, ZIP)* | | ADDITIONAL MAILINGS REQUESTED<br>☐ Yes ☐ No | |

| SCHOOL PREVIOUSLY ATTENDED | SCHOOL DISTRICT PREVIOUSLY ATTENDED | PREVIOUS SCHOOL LOCATION (City and State) |
|---|---|---|
| HAS STUDENT EVER ATTENDED ANACORTES SCHOOL DISTRICT PUBLIC SCHOOLS? ☐ Yes ☐ No<br>IF YES, NAME OF SCHOOL ATTENDED | | DATE ATTENDED (Month/Year) |

HAS THE STUDENT EVER BEEN SUSPENDED OR EXPELLED FOR A WEAPONS VIOLATION? ☐ Yes ☐ No Date: ___________________________________

IS THERE A JOINT-CUSTODY OR PARENTING DOCUMENT IN EFFECT? ☐ Yes ☐ No (If yes, document must be on file with the school for enforcement)

Who has legal custody of this child? (Last, First, Middle Initial) ______________________________________________________ Relationship to Child_______________________________

IS THERE A RESTRAINING ORDER IN EFFECT? ☐ Yes ☐ No (If yes, legal papers must be on file with the school for enforcement)

Restraining order is against: ☐ Mother ☐ Father ☐ Other ______________________________________________________________________

| | |
|---|---|
| HAS YOUR CHILD EVER BEEN ENROLLED IN A SPECIAL ED PROGRAM? ☐ Yes ☐ No | HAS YOUR CHILD EVER BEEN RETAINED? |
| HAS YOUR CHILD EVER HAD A 504 PLAN? ☐ Yes ☐ No | ☐ Yes ☐ No |
| HAS YOUR CHILD EVER PARTICPATED IN: ☐ Title ☐ LAP ☐ Gifted ☐ ESL ☐ Speech ☐ Other _______________ | If yes, at what grade level(s)____________________ |

**-OVER-**

**PLEASE COMPLETE SIDE TWO**

| DOES STUDENT ATTEND CHILD CARE?<br>☐ Before school ☐ After school ☐ Before and after school | CHILD CARE PROVIDER *Name* *Address* *Phone Number* |
|---|---|
| ADDITIONAL CHILD CARE ARRANGEMENTS (Please provide information to school in writing) | |

PLEASE LIST OTHER SIBLINGS

| Last Name First Name | School | Grade |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

SPECIAL INSTRUCTIONS REGARDING RELIGIOUS BELIEFS (Please provide information to school in writing)

**EMERGENCY MEDICAL AUTHORIZATION:** I understand that in the event of accident or illness, every effort will be made to contact parent/guardian immediately. If parent/guardian cannot be reached, I authorize school authorities to obtain emergency care for my child.

Please list any medications this child will be taking during school hours: ______________________________

Please list any known allergies: ______________________________

Required treatment for allergies: ______________________________

Other life threatening conditions:______________________________

*Legal Parent/Guardian Signature* ______________________________ *Date* ____________________

When injury, illness or other non-emergency situations occur involving your child, we want to be able to quickly reach families or other responsible adults. In the event we cannot reach a parent/guardian, please list persons you trust who are available during the day to provide care for your child.

| PRIMARY CONTACT (other than parent/guardian)<br>*Last Name* *First Name* | RELATIONSHIP TO CHILD | PHONE #1 (include area code)<br>☐ Home ☐ Work ☐ Cell | PHONE (include area code)<br>☐ Home ☐ Work ☐ Cell |
|---|---|---|---|
| PRIMARY CONTACT ADDRESS *Street* *City,* *State,* *ZIP* | | | |
| SECONDARY CONTACT (other than parent/guardian)<br>*Last Name* *First Name* | RELATIONSHIP TO CHILD | PHONE #1 (include area code)<br>☐ Home ☐ Work ☐ Cell | PHONE (include area code)<br>☐ Home ☐ Work ☐ Cell |
| SECONDARY CONTACT ADDRESS *Street* *City,* *State,* *ZIP* | | | |
| THIRD CONTACT (other than parent/guardian)<br>*Last Name* *First Name* | RELATIONSHIP TO CHILD | PHONE #1 (include area code)<br>☐ Home ☐ Work ☐ Cell | PHONE (include area code)<br>☐ Home ☐ Work ☐ Cell |
| THIRD CONTACT ADDRESS *Street* *City,* *State,* *ZIP* | | | |

**STUDENT RELEASE AUTHORIZATION**: In the event that the school is unable to contact the parent/guardian, I authorize that my child may be released to the person(s) listed above.

*Legal Parent/Guardian Signature* ______________________________ *Date* ____________________

**VERIFICATION OF INFORMATION**: The information on this form is true and accurate as of this date. I understand that falsification of information to achieve enrollment or assignment may be cause for revocation of the student's enrollment or assignment to a school in the Anacortes School District Public Schools.

*Legal Parent/Guardian Signature*______________________________ *Date*____________________

# Need More Information About Our Schools?

***Check us out on the Web***

| | |
|---|---|
| Mt. Erie: | mte.asd103.org |
| Whitney: | wht.asd103.org |
| Island View: | isv.asd103.org |
| Fidalgo: | fid.asd103.org |

Anacortes School District: www.asd103.org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Anacortes School District: www.asd103.org

# ANACORTES SCHOOL DISTRICT
# STUDENT HEALTH INFORMATION

Student Name Birthdate Grade

Please check any health concern you or your doctor have noticed:
**Are any of these conditions considered "Life Threatening"? Yes ____ No ____**
**If so, please notify the school nurse for further instruction to protect your child at school.**
**MEDICAL HISTORY: PLEASE CHECK APPROPRIATE BOX. IF YES, COMMENT AND GIVE DATES.**

| NO | YES | |
|---|---|---|
| ☐ | ☐ | **ADD/ADHD (hyperactivity)** If yes, does student take medication?_____ If yes, what type?____________ |
| ☐ | ☐ | **ASTHMA** |
| ☐ | ☐ | **Allergies (bee sting / food / other)** |
| ☐ | ☐ | **DIABETES** |
| ☐ | ☐ | **SEIZURES (Epilepsy)** |
| ☐ | ☐ | Loss of consciousness / serious blows to the head |
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Meningitis / Encephalitis |
| ☐ | ☐ | Nose bleeding |
| ☐ | ☐ | Sinus trouble |
| ☐ | ☐ | Recurrent ear infections (more than 2 per year) |
| ☐ | ☐ | Ear tube placement |
| ☐ | ☐ | Hearing aids / problems |
| ☐ | ☐ | Stomach aches / indigestion |
| ☐ | ☐ | Diarrhea / vomiting |
| ☐ | ☐ | Heart trouble, blood disease |
| ☐ | ☐ | Kidney disease |
| ☐ | ☐ | Chest / lung problems |
| ☐ | ☐ | Bone / Joint problems |
| ☐ | ☐ | Hospitalizations / operations |
| ☐ | ☐ | Depression / emotional health issues |
| ☐ | ☐ | Receiving ongoing medical treatment |
| ☐ | ☐ | Daily medication: Type____________ Dosage__________ When_________ (including inhalers) |
| ☐ | ☐ | Does medication need to be administered at school? |
| ☐ | | Adult supervision required during school hours:____________ Explain:____________ |

Other medical information that would be helpful for the school to know:____________

____________

Family Physician: ____________ ____________ ____________

Name Address Phone

Family Dentist: ____________ ____________ ____________

____________ ____________

Signature of Parent/Guardian Date

*SHI* *Rev. 04/07*

C:\Documents and Settings\jgammache\Desktop\kroundup\Roundup Student Health Information Form.doc

# VACCINES REQUIRED FOR SCHOOL ATTENDANCE, GRADES K-12[1]

## July 1, 2009 – June 30, 2010

**Month, Day & Year** are required documentation of all vaccines.

| VACCINE[2] | Kindergarten | 1st Grade | 2nd-3rd Grades | 4th-5th Grades | 6th Grade | 7th-8th Grades | 9th-12th Grades |
|---|---|---|---|---|---|---|---|
| **HEPATITIS B**<br>• Series must **NOT** be completed in less than 4 months. Series should be completed within 9 months of starting school. | **3 doses**<br>2nd dose can be given at least 1 month (24 days) after the 1st dose.<br>3rd dose must be given at or after 6 months (24 weeks) of age.<br>3rd dose must be given at least 2 months after the 2nd dose.<br>3rd dose must be given at least 4 months after the 1st dose.<br>If the student receives 2 doses of an adolescent formulation of Recombivax HB between ages 11 and 15, separated by 4 months, the student's immunization status is "complete." | | | | | | |
| **DTaP/DT/Td/Tdap**<br>• Those older than 7 should not receive DTaP.<br>• After the 7th birthday, children should receive Td or Tdap. | **4 doses DTaP** **IF** the last dose is given on or after the 4th birthday. | **3 doses DTaP, DT or Td** **IF** the last dose is given on or after the 4th birthday. | | | **3 doses DTaP, DT or Td** **IF** the last dose is given on or after the 4th birthday **AND** **1 dose Tdap** **IF** student is 11 years old and **IF** it has been at least 5 years since the last DTaP, DT or Td. | | **3 doses DTaP, DT or Td** **If** the last dose is given on or after the 4th birthday. **Tdap** may substitute for 1 of the 3 doses. |
| **POLIO (IPV or OPV)**<br>• Students 18 years and older are not required to have IPV or OPV. | **4 doses** **IF** all doses are given before the 4th birthday.<br>**3 doses** **IF** the last dose is given on or after the 4th birthday. | | | | | | |
| **MMR**<br>• Blood test (titer) showing immunity to measles, mumps or rubella is acceptable. | **2 doses**<br>1st dose must be given on or after the 1st birthday (4 day grace applies).<br>2nd dose must be given at least 28 days after the 1st dose (4 day grace **DOES NOT** apply). | | | | | | |
| **VARICELLA**<br>• Varicella must be received the same day as MMR **OR** at least 28 days apart (4 day grace **DOES NOT** apply).<br>• The minimum interval between varicella doses for children < 13 years of age is 28 days (recommended interval is 3 mos).<br>• Blood test (titer) showing immunity to varicella and/or provider diagnosis/verification of disease is acceptable. | **2 doses**<br>Must be given on or after the 1st birthday (4 day grace applies).<br>Parent-reported history of disease **NOT** acceptable. | | **1 dose**<br>Must be given on or after the 1st birthday (4 day grace applies). Parent reported history of disease is acceptable. | **Recommended, but not required** | **1 dose**<br>Must be given on or after the 1st birthday (4 day grace applies). Parent reported history of disease is acceptable. | **Recommended, but not required** | |

[1] To attend public/private school or licensed child care in WA State, each child must present a signed **Certificate of Immunization Status form** showing proof of 1) full immunization per the 2007 Recommended Childhood Immunization Schedule (see **http://www.doh.wa.gov/cfh/Immunize/schools/vaccine.htm**), 2) an initiation of a schedule of immunization, 3) a medical exemption (with health care provider signature), **OR** 4) personal or religious exemption (with a parent/guardian signature).

[2] There is no maximum interval between doses. Even if the recommended interval is not met, the series does not need to be restarted. Vaccine doses given ≤ 4 days before the minimum interval or age are valid, except for the intervals between MMR doses, varicella doses and MMR and varicella doses.

| Reviewed by: | Date: |
|---|---|
| Staff Signature | |

Is there an accompanying signed Certificate of Exemption on file?
❑ Yes ❑ No

DOH 348-013
Rev: 10/15/08

# Certificate of Immunization Status (CIS)

| Child's Last Name: | First Name: | Middle Initial: | Child's Address: |
|---|---|---|---|
| Child's Birthdate: | | Child's Sex: | |
| Parent/Guardian Name: | | | Parent/Guardian Day Phone: |

**If completing by hand, write the vaccine in the row to the left of "Dose" and the date the vaccine was received in the "Date" column. Age column is optional.**

◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only

| Vaccine | Dose | Date | Age |
|---|---|---|---|
| **◆ Hepatitis B (Hep B)** | | | |
| | 1 | | |
| | 2 | | |
| | 3 | | |
| | | | |
| **Hepatitis B (Hep B)** Alternate schedule for teens | | | |
| | 1 | | |
| | 2 | | |
| **Rotavirus** | | | |
| | 1 | | |
| | 2 | | |
| | 3 | | |
| **◆ Diphtheria, Tetanus, Pertussis** (DTaP, DTP, DT) | | | |
| | 1 | | |
| | 2 | | |
| | 3 | | |
| | 4 | | |
| | 5 | | |
| | | | |
| **◆ Diphtheria, Tetanus, Pertussis** (Tdap, Td) | | | |
| | 1 | | |
| | 2 | | |
| **● *Haemophilus influenzae* type b (Hib)** | | | |
| | 1 | | |
| | 2 | | |
| | 3 | | |
| | 4 | | |

See the back of this page for documentation of immunity, a vaccine trade name reference guide, and a vaccine abbreviation list.

| Vaccine | Dose | Date | Age |
|---|---|---|---|
| **● Pneumococcal (PCV, PPV)** | | | |
| | 1 | | |
| | 2 | | |
| | 3 | | |
| | 4 | | |
| | | | |
| **◆ Polio (IPV, OPV)** | | | |
| | 1 | | |
| | 2 | | |
| | 3 | | |
| | 4 | | |
| | | | |
| **Influenza (most recent)** | | | |
| | | | |
| | | | |
| | | | |
| **◆ Measles, Mumps, Rubella (MMR)** | | | |
| | 1 | | |
| | 2 | | |
| | | | |
| | | | |
| **◆ Varicella (chickenpox)** | | | |
| | 1 | | |
| | 2 | | |

| Vaccine | Dose | Date | Age |
|---|---|---|---|
| **Hepatitis A (Hep A)** | | | |
| | 1 | | |
| | 2 | | |
| | | | |
| **Meningococcal (MCV4, MPSV4)** | | | |
| | 1 | | |
| | | | |
| **Human Papillomavirus (HPV)** | | | |
| | 1 | | |
| | 2 | | |
| | 3 | | |
| | | | |
| **Other** | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**I certify that the information provided here is correct and verifiable.**

Signature of Parent or Guardian Date

**▼ Verification of varicella disease history ▼**

| | | |
|---|---|---|
| ❑ Health Care Provider (HCP) Verified ▶ | ❑ Signed note from HCP attached **or**<br>❑ HCP provider signature here: ▶ | **Licensed HCP Signature (MD, DO, ND, PA, ARNP)** **Date** |
| ❑ HCP Verified by Registry ▶ | No HCP Sig required if box at left checked. **If school staff find verification in the Registry, then school staff must:** ▶ | **Either** initial with parent approval or get parent signature below:<br>Staff initials indicating parent approval: ________ |
| ❑ Parental Report ▶ | **ONLY** acceptable for some grades. Write date or age child had disease: | Parent Signature indicating approval: ________ |

## Documentation of Immunity by Blood Test (titer)

**I certify that the child named on this form has laboratory evidence of immunity to (check all that apply):**

☐ Diphtheria ☐ Hepatitis A ☐ Hepatitis B ☐ Hib ☐ Measles ☐ Mumps ☐ Polio ☐ Rubella ☐ Tetanus ☐ Varicella

☐ Other (list): ☐ lab report(s) attached (required)

X

Typed or Printed Name of **Licensed Health Care Provider** (MD, DO, ND, PA, ARNP)

X

Signature of **Licensed Health Care Provider** (required) Date (required)

## Vaccine Trade Names*

**Read down and across - Trade Names are in Alphabetical Order.**

| Trade Name | Vaccine | Trade Name | Vaccine |
|---|---|---|---|
| Acel-Imune | DTaP | Menomune | MPSV4 |
| ActHIB | Hib | OmniHIB | Hib |
| Adacel | Tdap | Pediarix | DTaP + IPV + Hep B |
| Boostrix | Tdap | PedvaxHIB | Hib |
| Certiva | HPV | Pentacel | DTaP + IPV + Hib |
| Comvax | Hib + Hep B | Pentavalente | DTaP + Hep B + Hib |
| Daptacel | DTaP | Pneumovax | PPV23 |
| Decavac | Td | Prevnar | PCV or PCV7 |
| Engerix-B | Hep B | ProHIBiT | Hib |
| Fluarix | Flu | ProQuad | MMRV |
| FluMist | Flu | Quadracel | DTaP + IPV |
| Fluvirin | Flu | Recombivax | Hep B |
| Fluzone | Flu | Rotarix | Rotavirus |
| Gardasil | HPV | RotaTeq | Rotavirus |
| Havrix | Hep A | Tetramune | DTP + Hib |
| HibTITER | Hib | TriHIBit | DTaP + Hib |
| HyperTET | TIG | Tri-Immunol | DTP |
| HyperHEP B | HBIG | Tripedia | DTaP |
| Ipol | IPV | Twinrix | Hep B + Hep A |
| Infanrix | DTaP | Vaqta | Hep A |
| Kinrix | DTaP + IPV | Varivax | Varicella |
| Menactra | MCV4 | | |

## Vaccine Abbreviations*

**Read down – Abbreviations are in Alphabetical Order.**

| Abbreviations | Full Vaccine Name |
|---|---|
| DT | Diphtheria, Tetanus |
| DTaP | Diphtheria, Tetanus, acellular Pertussis |
| DTP | Diphtheria, Tetanus, Pertussis |
| Flu (TIV or LAIV) | Influenza |
| HBIG | Hepatitis B Immune Globulin |
| Hep A (HAV) | Hepatitis A |
| Hep B (HBV) | Hepatitis B |
| Hib | *Haemophilus influenzae* type b |
| HPV | Human Papillomavirus |
| IPV | Inactivated Poliovirus Vaccine |
| MCV4 | Meningococcal Conjugate Vaccine |
| MPSV4 | Meningococcal Polysaccharide Vaccine |
| MMR | Measles, Mumps, Rubella |
| MMRV | Measles, Mumps, Rubella, Varicella |
| OPV | Oral Poliovirus vaccine |
| PCV or PCV7 | Pneumococcal Conjugate Vaccine |
| PPV23 | Pneumococcal Polysaccharide Vaccine |
| Rota (RV1 or RV5) | Rotavirus |
| Td | Tetanus, Diphtheria |
| Tdap | Tetanus, Diphtheria, acellular Pertussis |
| TIG | Tetanus immune globulin |
| VAR or VZV | Varicella |

***These lists may not be comprehensive; visit http://www.doh.wa.gov/cfh/immunize/forms/default.htm for updated lists.**

# Certificate of Exemption (COE)

**From School, Child Care and Preschool Immunization Requirements**[1]

**DOH 348-106 Revised: 10/15/08**

| Child's Last Name: | First Name: | Middle Initial: | Child's Address: |
|---|---|---|---|
| Child's Birthdate: | | Child's Sex: | |
| Parent/Guardian Name: | | | Parent/Guardian Day Phone: |

**Please choose the exemption(s) that apply to your child as listed below.**

☐ **Temporary Medical Exemption**

☐ **Permanent Medical Exemption**

I certify that the child named on this form is medically exempted from the requirement for the following vaccine(s):

Until

Vaccine(s) ______ Date (or Perm.)

X

Type or Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X

Signature of Licensed Health Care Provider ______ Date

☐ **Personal/Philosophical Exemption**

☐ **Religious Exemption**

I do not want my child to get the following vaccine(s).

- ☐ Diphtheria
- ☐ Hepatitis B
- ☐ Hib
- ☐ Measles
- ☐ Mumps
- ☐ Pertussis (whooping cough)
- ☐ Pneumococcal
- ☐ Polio
- ☐ Rubella
- ☐ Tetanus
- ☐ Varicella (chickenpox)

☐ Other (indicate):

**Parent/Guardian Notice:** "I certify that the information provided here is correct and verifiable. I understand that if there is an outbreak of a vaccine-preventable disease my child has not been fully immunized against (as indicated above, for medical, personal/philosophical or religious reasons), my child may be at risk for disease and can be **excluded** from school, child care or preschool until the outbreak is over."

Signature of Parent/Guardian ______ Date

[1] RCW 28A.210.080-090 state that before or on the first day of every child's attendance at any public and private school or licensed day care center in Washington State 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. Medical exemptions must be signed by a licensed health care provider.

**KINDERGARTEN** Name: ______________________________

## GENERAL HEALTH HISTORY

1. Please check any health concern that you or your doctor have noticed:
   **Are any of these conditions considered "life threatening"?** ______yes ______no

| | | |
|---|---|---|
| ____**Asthma** | ____ADD/ADHD (hyperactivity) | ____**Allergies** |
| ____Bed Wetting | ____Constipation | ____**Diabetes** |
| ____Chronic ear infections (more than 2 per year) | | ____Ear tubes |
| ____Diarrhea/vomiting | ____Indigestion | ____Stomachaches |
| ____**Seizures** | ____Headaches | ____Serious blows to the head |
| ____Loss of consciousness | ____Nose Bleeding | ____Sinus Trouble |
| ____Frequent fevers | ____Heart trouble, blood disease | ____Kidney Disease |
| ____Chest/lung problems | ____Nightmares | ____Nail biting |
| ____Thumb sucking | ____Strong fears | ____Over tired or lacking energy |

____Medical problems immediately after birth

_____Receiving ongoing medical treatment

Explain:______________________________________________________________

______________________________________________________________

2. Is this child presently on medication?______________ What?______________________________
3. Has child had any significant injuries or hospitalization?______________________________
4. Is child healthy on day of screening?______________________________

## HEARING ASSESSMENT

1. Has this child ever had any ear/hearing examination or treatment? ______Yes ______No

   When ________________ By whom ____________________ Results ________________

| | *Yes* | *No* |
|---|---|---|
| 2. Do you suspect any hearing problems? | ______ | ______ |
| 3. Does this child: | | |
| ° Seem to have difficulty hearing? | ______ | ______ |
| ° Turn up the TV louder than other members of the family? | ______ | ______ |
| ° Seem to favor one ear over the other? | ______ | ______ |
| ° Jump or appear to be more startled than others if there is a sudden noise? | ______ | ______ |
| ° Seem to hear you if you talk in a whisper? | ______ | ______ |
| ° Make you talk loudly or repeat frequently? | ______ | ______ |

## VISUAL ASSESSMENT

1. Has this child ever had a vision examination or treatment? ______Yes ______No

   When ________________ By whom ____________________ Results ________________

| | *Yes* | *No* |
|---|---|---|
| 2. Do you suspect any vision problems? | ______ | ______ |
| 3. Does this child: | | |
| ° Seem to have difficulty seeing small lines or pictures? | ______ | ______ |
| ° Seem to have a problem seeing things far away? | ______ | ______ |
| ° Squint? | ______ | ______ |
| ° Wear glasses? | ______ | ______ |
| ° Have eyes that turn in? | ______ | ______ |
| ° Have eyes that turn out? | ______ | ______ |

**KINDERGARTEN**

Name: ______________________________

## DEVELOPMENTAL BACKGROUND

1. This child began walking at (give approximate age if you do not remember exact age): Age __________

2. At what age did this child first begin to speak? (Give approximate age if you do not remember exact age)

   Age ______ First words

   Age ______ Two or three words together

   Age ______ Sentences

3. Has the child attended a preschool? ____ Yes ____ No

4. Does this child know how to read? ____ Yes ____ No

5. Does this child know how to write? ____ Yes ____ No

6. Is there any other information that will help us understand this child?

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

7. Concerns: Please explain any reservations you have about this child starting kindergarten this year.

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

**Thank you for your patience in filling out this questionnaire.**

# Anacortes School District
# Home Language Survey

| Student's Name | Date |
|---|---|
| School | Grade |

1. ____Yes ____ No Is a language other than English spoken in the home?

If yes, list languages ____________________ ____________________
____________________ ____________________

2. ____Yes ____ No Is your child's first language a language other than English?

If yes, list languages ____________________ ____________________
____________________ ____________________

**If you answered "Yes" to question number two above, please complete the information below, including questions A and B:**

____________________ ____________________
Student's Country of Birth Student's Date of Birth

____________________ ____________________
Parent or Guardian's Name Phone Number

____________________ ____________________ ____________
Current Address City, State Zip Code

**The following information is collected for the State Transitional Bilingual Instruction Program end-of-year report, and is not part of the Home Language Survey.**

A. ______ For how many months has the student attended school in the United States (grades K – 12) before enrolling in this district? DOD schools are considered to be in the US.

B. ______ For how many months has the student received formal education outside the United States in his/her native language (equivalent to grades K – 12) before enrolling in this district?

Guidance:
- One (1) school year = ten (10) months.
- "Formal education" does not include refugee camp schools or other unaccredited programs for children.
- "Native Language" refers to the family's first language or dominant language.

***Reference to WAC392-160-005.***
- *"Primary language" means the language most often used by a student (not necessarily by parents, guardians, or others) for communication in the student's place of residence.*

# Anacortes School District
# Encuesta Sobre el Idioma del Hogar

| Nombre del Estudiante | Fecha |
|---|---|
| Escuela | Grado |

1. ____Sí ____ No ¿Una lengua otra del Inglés la lengua primaria* se utiliza en su casa?

Sí, idiomas de la lista ____________________ ____________________
____________________ ____________________

2. ____ Sí ____ No ¿Es la lengua primaria* de su niño una lengua otra de Inglés?

Sí, idiomas de la lista ____________________ ____________________
____________________ ____________________

**Si usted repondió "sí" a pregunta dos arriba, favor de proporcionar la información abajo, incluyendo las preguntas A y B:**

____________________ Pais donde nacio el estudiante

____________________ Fecha de nacimiento del estudiante

____________________ Nombre de la madre, el padre, o el tutor

____________________ Número del teléfono

____________________ Dirección

____________________ Ciudad, Estado

__________ Código

**La información siguiente se recoge para el informe de final de año del programa bilingüe transitorio de la instrucción del estado, y no es la parte de la encuesta sobre casera la lengua.**

A. ______ ¿Por cuántos meses el estudiante ha atendido a la escuela en los Estados Unidos (grados K - 12) antes de alistar en este districto?

B. ______ ¿Para cuántos meses tienen el estudiante recibió la enseñanza fuera de los Estados Unidos en el lengua materna (equivalente a los grados K - 12) antes de alistar en este districto?

Información Adicional:
- Un (1) año escolar = diez (10) meses
- La "enseñanza convencional" no incluye escuelas del campo del refugiado o otra unaccredited programas para los niños.
- La "lengua materna" refiere a la primera lengua de la familia o la lengua dominante.

***Referencia a WAC392-160-005.***
- *La "lengua primaria" significa la lengua usada lo más a menudo posible por un estudiante (no necesariamente por los padres, guardas, u otros) para la comunicación en el domicilio del estudiante.*