REGISTRATION FORM The Shyne School

13613 Avondale RD NE Woodinville, WA 98072 (425)882-1981

Child's Information

Full Name: _____Nick Name: _____ Birth Date: _____
Enrollment Date: __/__/__ Last Physical: __/__/__ Child's Sex: __ Boy __ Girl
Address: _____ City: _____, WA Zip: _____
Home Phone: (____) _____ the Child Lives With: _____

Guardian's Information:

Name: _____ Password: _____ Clock In Code: _____
Relationship to Child: _____ E-Mail: _____
Place of Business: _____ Work Phone: _____
Cell Phone: (___) _____ Other Contact: _____
(If different from above)
Address: _____ City: _____ State: _____
Zip: _____ Home Phone: (____) _____

Name: _____ Password: _____ Clock In Code: _____
Relationship to Child: _____ E-Mail: _____
Place of Business: _____ Work Phone: _____
Cell Phone: (___) _____ Other Contact: _____
(If different from above)
Address: _____ City: _____ State: _____
Zip: _____ Home Phone: (____) _____

Emergency Contact:

If we cannot reach you list three people we can contact locally that can pick up your child.

Name	Home Phone	Cell Phone	City	Relationship

Authorized Pick Up:

List two people that can pick up your child that are local and list one out of state contact.

Name	Home Phone	Cell Phone	City/State	Relationship

Guardian's Signature & Date: _____

Please attach documentation for any specific people NOT authorized to pick up your child

Tuition Agreement The Shyne School

13613 Avondale RD NE Woodinville, WA 98072 (425)882-1981 www.shyneschool.com

Child's Name: _____ Enrollment Date: _____/_____/20_____
Schedule: ***Circle Days*** M T W TH F Arrive: ____:___ AM/PM and picked up: ____:___ AM/PM
Classroom: _____ Teachers: _____
The Shyne School will transport my child to and from _____Elementary School

Registration Fees

· A onetime registration fee of $50 per child is due at the time of enrollment.
· An annual academic fee of $50 per child is due at the time of enrollment & for each subsequent school year for re-enrollment.
· An emergency kit with a 5 year shelf life, at a fee of $15, is yours to take when you leave. *(Food, water, light stick, emergency blanket & rain poncho)*

Tuition & Late Payments

· Tuition is charged on a monthly basis. Billing is done by the first of each month. You will receive a statement at the end of the month, for the following month. Payment is due on the 1st of each month and by the fifth to avoid a late fee of $25. Accounts are set up for monthly billing unless other arrangements have been made with the office. If you arrange to submit tuition bi-monthly the second tuition payment is due by the 15th of each month and must be received by the 20th of each month to avoid a late fee of $25. Receipts are available upon request.
· To avoid a late fee you need to make alternate payment arrangements ahead of time with the director. If you do not make prior arrangements you will receive a late fee and notice on the 6th to pay or we will have no choice but to terminate your child's enrollment on the 8th of the month. Expenses incurred for the collection of delinquent accounts will be the responsibility of the parents. The Shyne School reserves the right to deny care to any family that is delinquent on their account.
· Tuition will be revised annually. You will be given thirty (30) days written notice prior to any rate or policy changes.
· It is important to us to maintain a secure and stable environment for your child(ren). In order to accomplish this, we must offer our staff the security of knowing their employment with The Shyne School is also secure and stable. Tuition fees remain constant regardless of holidays. Parents do not pay for the days we are closed or their children are on break, it is figure into the tuition for the year. Our fees are based on an average of twenty (20) days per month, four (4) weeks a month. This amounts to 240 days per calendar year for full time and 180 days part time per preschool year. Families attending full days, year round, receive free days per their schedule. **Credits will not be issued for closures due to weather if they do not exceed free extra days each year. Make up days are added to the end of the year for preschool Only or Plus days missed.*
· A multiple child discount applies to Preschool Plus and Full Day families with a 5% discount off the total bill.

Late Pick-up

· The Shyne School is open from 7:00 AM to 6:00 PM for full day students attending 5 to 10 hours. A charge of $1 a minute applies to students exceeding these times. After 15 minutes if we are unable to contact the parents and confirm that they are on their way we will call the child's emergency contacts to pick up. After 10 minutes a charge of $2 a minute applies to students exceeding closing times. Legal authorities will be contacted for children left at the center more than one hour past closing if we are unable to arrange for the child to be picked up.
· Preschool Only and Preschool Plus Students will be charged an hourly fee past their scheduled departure time. Due to parking limitations parent you are given 15 minutes after scheduled pick up time when parking is an issue. If your child will be staying longer then their scheduled day it must be approved by the director.

Vacation Credit

· A vacation credit of 100% off one wk regular tuition is available to our full time families. A Year is defined as Sept.1-Aug. 31st.
· The criteria for using vacation credit are as follows: ***1.*** *Vacations must be scheduled in advance.* ***2.*** *Students must be enrolled longer than 4 months to receive a credit. 3****.*** *Families must be enrolled and attend for summer session.* ***4.*** *If you use a vacation credit and withdrawal before summer you will be charged for the previous credit received.*

Schedule Changes/Withdrawal Policy

· A two week advance written notice for any schedule changes or child being withdrawn from the school is required in writing. If notice is e-mailed you must receive confirmation.
· Schedule changes are approved on a space available basis.

I, the legal guardian of the child listed above have read the above enrollment agreement which shall become part of my obligation to The Shyne School. I fully understand this obligation and the reason for its implementation.

_____	_____	_____	_____
Guardian Name Printed	**Guardian Signature**	**Date**	**Driver License #**

Overall Consent Form The Shyne School

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Permission for Center Activities

With prior notification given, I hereby give my permission for my child, to:

1. Participate in field trips arranged by The Shyne School. __Yes __No
2. Be transported by The Shyne School staff for field Trips. __Yes __No
3. Be transported by another parent with full insurance coverage for field trips __Yes __No
4. Be transported by The Shyne School staff to and from Elementary School. __Yes __No
5. Walk up to and play in The Shyne School Woods. __Yes __No
6. Be photographed for use in center projects (non-commercial use only) __Yes __No
7. Be photographed at school and posted to the school web site __Yes __No
8. Be photographed at school and posted to the school face book page __Yes __No

I hereby give my permission for the school to give out my:

1. Address __Yes __No,
2. Phone number __Yes __No
3. E-mail __Yes __No

They will be listed on a class roster (*to set up play dates with other students)* or as a referral to new parents.

Consent for Medical Treatment and Transport

I,_____ , the legal guardian of_____ , hereby give permission that he/she me be given emergency treatment to include first aid and CPR by a qualified child care staff member at The Shyne School. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by my child's regular physician, or when that physician cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

Doctor: _____ Doctor's Phone Number: _____
Hospital of Choice: _____ Blood Type: _____
Allergies Including Drug Reactions: _____
Regular Medications: _____
Any known medical problems or chronic illness: _____
Insurance Coverage: _____
Membership #: Group #: _____
Employer: _____

Guardian #1 Name & Work #: _____
Guardian #2 Name & Work #: _____

Guardian Signature & Date: _____

Developmental & Health Form The Shyne School

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Name of Child: _____ Birthday: ___/___/___ Today's Date: ___/___/___

Family History

Please list who the child lives with and any special circumstances regarding living arrangements and custody: _____

_____

Is your child's primary language English? __ Yes __ No If no, please list languages, other than English, spoken at home: _____

Please list family heritage and Holidays special to your family: _____

_____

Information we may find helpful: _____

_____

Child's Developmental History

Toileting:

My child uses that bathroom on their own and asks to go: __Yes __No requires help: ___Yes __No

Words used for Toileting and other information we may find helpful: _____

_____

Eating:

My child is vegetarian: ___ Yes __ No If Yes list foods your child may NOT eat: _____

_____

My child has food allergies or restrictions: ___Yes ___No Please list food allergies and reactions: ___

_____

Please list dietary restrictions: _____

Information we may find helpful: _____

_____

Sleeping:

Does your child nap? ___Yes ___No If yes, please describe napping pattern, comforts and any other information we may find helpful: _____

_____

Social:

Has your child had group play experience before? ___Yes ___No If yes, please list where and what kind of experience: _____

_____

When your child is upset, what works to comfort them? _____

_____

How does your child express anger and/or frustration? _____

What method of behavior management do you use at home? _____

_____

What is your child's usual reaction? _____

How would you describe your child's personality? _____

Information we may find helpful: _____
_____

Cognitive & Physical:

What are your child's favorite activities? _____
What are your goals for your child? _____
Does your child have any special fears? Explain, _____
_____
Does your child require help with self-help skills? (Example: dressing self, wiping, eating…) Explain, _
_____
Information we may find helpful: _____
_____

Child's Health History

Does your child have any speech or hearing problems? ___Yes ___No If yes, please explain, _____
_____
Does your child have any special needs or diagnosis? ___Yes ___No If yes, please explain, _____
_____
Does your child have any difficult behaviors? ___Yes ___No If yes, please explain, _____
_____
What special accommodations does your child need? _____
_____
Has your child had any serious accidents? ___Yes ___No If yes, please explain, _____
_____
When was your child last seen by a dentist? __/__/__ *It is recommended that they have their first check up by age 2.*
Family Dentist: _____ Dentist Phone (____) _____
Date of last Tetanus shot: __/__/__
Date of yearly medical exams: __/__/__, __/__/__, __/__/__, __/__/__
Information we may find helpful: _____
_____
_____
_____
_____

If there is additional information about your child or family please let us know, _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Filled out by: _____
(Please print name)

Certificate of Immunization Status (CIS)

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 Immunization Registry.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (mm/dd/yyyy): **Sex:**

Symbols below: ◆ Required for School and Child Care/Preschool
● Required for Child Care/Preschool Only

Parent/Guardian Name (please print):

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required Date

Vaccine	Dose	Date Month	Day	Year
◆ **Hepatitis B (Hep B)**				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ **Diphtheria, Tetanus, Pertussis** (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ **Tetanus, Diphtheria, Pertussis** (Tdap, Td)				
	1			
	2			
● ***Haemophilus influenzae* type b (Hib)**				
	1			
	2			
	3			
	4			
● **Pneumococcal (PCV, PPSV)**				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date Month	Day	Year
◆ **Polio (IPV, OPV)**				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ **Measles, Mumps, Rubella (MMR)**				
	1			
	2			
◆ **Varicella (chickenpox)** or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			

Office Use Only: Immunization information updated and verified with parent/guardian permission:

Printed Staff Name Date | Printed Staff Name Date

Printed Staff Name Date | Printed Staff Name Date

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

1) ❑ Chickenpox disease verified by printout from CHILD Profile Immunization Registry
Must be marked by printout (not by hand) to be valid.

2) ❑ Chickenpox disease verified by Health Care Provider (HCP)
If you choose this box, mark 2A **OR** 2B below.
2A) ❑ Signed note from HCP attached **OR**
2B) ❑ HCP signed here and print name below:

Licensed health care provider (HCP) Signature Date
(MD, DO, ND, PA, ARNP)
HCP Printed Name:

3) ❑ Chickenpox disease verified by school staff from CHILD Profile Immunization Registry
If you choose this box, staff must initial that parent or guardian approves: (initial) (date)

4) ❑ Chickenpox disease verified by parent*
If you choose this box, fill in the date or child's age when he or she had the disease:
Age/Date of disease:
*Can **ONLY** verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.

Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked.
Signed lab report(s) MUST also be attached.

❑ Diphtheria
❑ Hepatitis A
❑ Hepatitis B
❑ Hib
❑ Measles
❑ Mumps
❑ Polio
❑ Rubella
❑ Tetanus
❑ Varicella
❑ Other:

Licensed health care provider (HCP) Signature Date
(MD, DO, ND, PA, ARNP)
HCP Printed Name:

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

EXAMPLE

Vaccine	Dose	Date		
		Month	Day	Year
◆ **Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)**				
DTaP	1	01	12	2011
DTaP	2	03	20	2011
DTaP	3	06	01	2011

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide 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**.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

1) ❑ If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
2) ❑ If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
3) ❑ If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
4) ❑ If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHibit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Kinx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twinrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menactra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqta	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrcl)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	*Haemophilus influenzae* type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

DOH 348-013 January 2010

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):

Vaccine(s) — Until 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.