Parent/Guardian Information- To be billed by WSU: WSU ID Number:_____

First Name:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____ Home Phone:_____

Cell Phone:_____ WSU Email:_____

WSU Department or Work Place:_____ Work Phone:_____

Work Hours:_____ Department Reception Phone Number:_____

Affiliation with WSU: ◯ Undergraduate ◯ Graduate Student ◯ Faculty ◯ Staff ◯ Other:_____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Parent/Guardian Information : ☐ None WSU ID Number:_____

First Name:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____ Home Phone:_____

Cell Phone:_____ Email:_____

WSU Department or Work Place:_____ Work Phone:_____

Affiliation with WSU: ◯ Undergraduate ◯ Graduate Student ◯ Faculty ◯ Staff ◯ None

Child Information

First Name:_____ Last Name:_____

Name child prefers to be called:_____ Gender: ◯ Male ◯ Female

Date of Birth (mm/dd/yyyy):_____/_____/_____ Primary Language used at home:_____

Lives With:_____ Enrollment Start Date (mm/dd/yyyy):_____

Enrollment Schedule:

☐ Full time: (7:30am-5:30pm) ☐ Part-Time: 7:30-12:30 or 12:30-5:30 ☐ Evening Care 5:30-9:30 M-Th

☐ School Age: (Before/After School Care and scheduled school closures)

Emergency Contact /Other than Parents/Guardians

Emergency Contact 1: First Name: _____ Last Name: _____

Cell phone: _____ Home Phone: _____ Gender: ◯ Male ◯ Female

Address: _____ Relationship to Child/Family: _____

Authorized to pick up child from WSUCC? ◯ Yes ◯ No

Is this contact person currently affiliated with WSU? ☐ No ☐ Yes, please specify _____

Primary language(s) spoken: _____

Emergency Contact 2: First Name: _____ Last Name: _____

Cell phone: _____ Home Phone: _____ Gender: ◯ Male ◯ Female

Address: _____ Relationship to Child/Family: _____

Authorized to pick up child from WSUCC? ◯ Yes ◯ No

Is this contact person currently affiliated with WSU? ☐ No ☐ Yes, please specify _____

Primary language(s) spoken: _____

Emergency Contact 3: First Name: _____ Last Name: _____

Cell phone: _____ Home Phone: _____ Gender: ◯ Male ◯ Female

Address: _____ Relationship to Child/Family: _____

Authorized to pick up child from WSUCC? ◯ Yes ◯ No

Is this contact person currently affiliated with WSU? ☐ No ☐ Yes, please specify _____

Primary language(s) spoken: _____

Guests to WSUCC: All guests (emergency contacts) will be required to identify themselves at the front desk and present a valid form of ID. If your guest will become a regular person who picks up your child, they can register for a computer code in our system. It may be requested of your guest to take a photo for our computer system for security purposes. All authorization for a person other than the parent/guardian checking children out of the Children's Center MUST be in writing.
Parents are responsible for updating all emergency contact information whenever it changes. WSUCC reserves the right to make contact with any and/or all of the emergency names listed above.
If there is a custody or other legal agreement/document that limits a parent/guardian's contact with a child or that prohibits a parent/guardian from picking up a child, WSUCC MUST have a copy of the legal document on file.

Parent/Guardian Signature:	**Date**
Printed Name:	

WSU CHILDREN'S CENTER SERVICE AGREEMENT

Family Information: Parent to be billed MUST be a WSU student, staff, or faculty member.

Parent to be billed by WSU: WSU ID Number:_____ Relationship to Child:_____

First Name:_____ Last Name:_____

WSU Email: _____ WSU Department or Student:_____

Affiliation with WSU: ◯ Undergraduate ◯ Graduate Student ◯ Faculty/Staff ◯ Other, Please Specify:_____

Parent 2: WSU ID Number:_____ Relationship to Child:_____

First Name:_____ Last Name:_____

WSU Email or other: _____ WSU Department or Student:_____

Affiliation with WSU: ◯ Undergraduate ◯ Graduate Student ◯ Faculty/Staff ◯ None

Child's Name:	DSHS Subsidized ☐ Yes ☐ No
Date of Birth:	CCAMPIS Eligible ☐ Yes ☐ No
Enrollment Start Date (mm/dd/yyyy):	ECEAP Eligible ☐ Yes ☐ No
Enrollment Classroom:	

Enrollment Schedule:

☐ Full time: 7:30-5:30 ☐ Part Time: 7:30-12:30 ☐ Part Time: 12:30-5:30 ☐ School Age: before/after school - 5:30
☐ Evening Care: Mon-Thurs, 5:30-9:30

Service Agreement Terms

Overtime charges:

- WSUCC opens at 7:30am and closes at 5:30pm for regular care
- Evening care is provided from 5:30 to 9:30pm Monday-Thursday during the academic year.
- Late pick-up: if a child is not picked up by closing time, a charge of $1 per minute may be assessed.

Billing

- Billing will be assessed, in advance, on a monthly basis.
- WSUCC will post billing information to a family's Procare account.
- Payment will be due by the 1st of the month (e.g. September invoice will be billed in August and payment is due by September 1st)
- A late fee of $35 will be assessed if payment is not received by the 5st of the month.
- Children will not be allowed to continue care past the 5th business by of the month without full payment or approved payment arrangement in place.
- Overtime charges (late pick-up fee) will be assessed based on actual charges incurred.
- Families starting enrollment mid-month will be billed on a pro-rated basis.

Payments - *No payments can be accepted at the Children's Center*

- Payments may be made online at www.childrenscenter.wsu.edu using Visa or MasterCard (or debit card displaying Visa/MasterCard logo).
- To pay by check or cash, payment can be made at the Cashier's Office in the French Administration Building, Room 342.

Policies and Procedures

- The most current Family Handbook is available online at www.childrenscenter.wsu.edu
- WSUCC reserves the right to update policies and practices on an as-needed basis in order to comply with state laws/regulations, university policies, and to ensure quality care.
- Families will be notified of any changes to policies and/or procedures.

WSU Children's Center Inclement Weather/Emergency Closure Policy

- As a "nonessential" service at WSU, if the university suspends operations (i.e. starts late) or closes due to weather or other emergencies, the Children's Center will close.
- If suspension of nonessential services (late start) occurs, the Children's Center will plan to open one hour prior to the time that the University identified to reopening.
- Children with part time schedules (infants through preschool morning or afternoon and school age children) will only be able to attend during their regularly scheduled times. See the family handbook for more details.

Closures: The WSU Children's Center follows the offical univeristy holiday and **non-essential** closure days.
Winter closure December 21,2016-Jan. 4, 2017. We will re-open for spring semester **January 5, 2017.** WSUCC is closed for Professional Development days on: **August 10-12, 2016 and August 9-11, 2017**

Tuition is established by taking all open days of service and dividing it by the 12 months. Therefore planned closures have been calculated as non-service days and not additionally prorated.

Enrollment Plan:

My child will attend WSUCC for the following semesters:

☐ Fall 2016 ☐ Spring 2017 ☐ Summer 2017 ☐ Fall 2017

Disenrollment advanced notice: The WSU Children's Center requires written notification two weeks in advance of the last day of attendance. Parent/Guardians who do not provide written notice two weeks in advance of their departure may be charged two weeks beyond the last day of their child's attendance.

Tuition rates are outlined on a separate rate sheet.
Tuition rates are subject to annual review and revision.

I have read and understand the terms of the service agreement as outlined above. I understand that if I have questions about my statement I may contact the billing office, and that the Children's Center policies are further outlined in the family handbook.

Parent Name Printed:	
Parent/Guardian Signature	Date

Child's Name:	Date of Birth:

Food Allergies, Intolerances, Restrictions, Preferences

☐ My child has a dietary restriction for medical reasons (such as a food allergy or other condition). If your child has dietary restriction **due to medical reasons, you MUST have your physician or health care provider complete a Food Allergy and Intolerance Form** as required by the State of Washington, Department of Early Learning licensing regulations. This form provides WSUCC with specific information and instructions related to your child's food intake restrictions.

☐ My child has food intolerance. If you know or suspect that your child has food intolerance **(not an allergy)**, we recommend that your health care provider complete the Food Allergy and Intolerance Form so that we have specific information and instructions related to your child's food intake restrictions.

☐ My child has a food restriction based on a religious/cultural value. Please eliminate the following food(s) from my child's diet:

- ☐ Beef
- ☐ Pork
- ☐ Other, please specify

☐ My child is a Vegetarian. Food Service will prepare Vegetarian meals/snacks per their food preparation policy. Please indicate type of vegetarian:

- ☐ **Lacto-Vegetarians:** Who eat plant foods plus dairy products
- ☐ **Lacto-ovo Vegetarians:** Who consume both dairy products and eggs
- ☐ **Vegans:** Who avoid all animal products- no dairy, and eggs and eat only vegetables, fruits, and grains
- ☐ **Semi-Vegetarians:** A semi-vegetarian could be a person who usually eats vegetarian but occasionally eats meat, for instance, or it could be someone who doesn't eat red meat but eats other meats.

Comments:

Additional Comments Related to Your Child's Food Needs:

Per policies and regulations of the USDA Child Care Food Program and the Washington State Department of Early Learning, WSUCC **must** offer milk at breakfast, lunch, and dinner (evening care). Milk may also be served as meal component at snack time. Milk will be offered to your child at these times **unless your child has medically documented milk allergy or intolerance.** WSUCC serves whole milk to children 1-2 years of age and fat-free milk to children above the age of 2 years.

Parent/Guardian Signature	Date

Family Handbook/Emergency/Emergency Disaster Plan/Health Care Policy & Fire Preparedness Plan
☐ I am aware that the WSUCC Family Handbook, Emergency Disaster Plan, Health Care Policy and Fire Preparedness Plan are available in booklet form or online at www.childrenscenter.wsu.edu . I have read and agree to abide by all of the policies and procedures as outlined in these documents and/or as amended by Washington State University. These handbooks include pertinent information such as licensing regulations, behavior management approaches, USDA Child Care Food Program, inclusion practices, billing procedures, open door policy, emergency disaster information, pesticide application practices, enrollment options, shelter-in-place precautions/procedures, and more. I understand that I may review a copy of these documents and/or receive a copy upon request.
☐ I authorize the WSU Children's Center to assess my child using professional developmental assessment tools including observation, Teaching Strategies Gold, and/or other similar assessment processes. These assessments will be used for the purpose of planning comprehensive individual and group learning opportunities. The information compiled using developmental assessment processes will be shared with me during parent-teacher conversation/conferences.
☐ I grant permission for my child to participate in all of the activities of the WSU Children's Center, under the supervision of a staff member, including classroom experiences, outdoor play, stroller rides, rainy day indoor play, and other developmentally appropriate opportunities.
☐ My child has/have permission to participate in walking field trips, under the supervision of a staff member. Walking field trips may include a variety of on-campus sites such as the art museum, parent offices, athletic facilities/functions, or other appropriate locations. Off-campus walking field trips may include sites such as parks, the public library, downtown locations, or other interesting locations. If a vehicle will be used to transport my child, I will be given an authorization form that I must sign that allows permission for my child to participate in that specific field trip experience.
Photos of the children will be taken for use in the Procare system, classroom allergy chart, and classroom use such as documentation of participation in learning experiences, preparation of child portfolios, observational processes, developmental assessment strategies, and similar purposes. In addition, I grant permission for photographic images (photos or videos) of my child to be taken by Children's Center staff and used for the following purpose(s). I understand that I will not receive compensation for the use of my child's photographs nor will I have ownership rights to the photographs/videos. ☐ WSU Children's Center use (e.g. inclusion in classroom/center-based newsletters, classroom activity summary pages, celebrations of success, and more.) ☐ WSU use (e.g. marketing materials such as the Children's Center flier, Family Handbook, or informational web pages, early childhood professional purposes such as documentation of quality care initiatives).

Child(ren) Information	
Child's Name	Date of Birth

Parent/Guardian Signature	**Date**

We want to do our best to make your child feel welcome.

Child's name and nickname?:_____

What are your child's likes?:_____

What are your child's dislikes?:_____

Favorite Toy?:_____

Favorite Story?:_____

Pets- Name and type of animals?:_____

_____

Favorite family activities?:_____

What makes him/her happy ☺?:_____

What makes him/her sad ☹?:_____

What are some favorite food?_____

What foods does he/she dislike?:_____

How does he/she like to be put down for a nap?:_____

_____

Does he/she have siblings? What are their name(s) and age(s)?:_____

_____

What other family members and friends are important to your child?_____

_____

The following space is provided for your to tell us about things you feel we should know about your child:_____

_____

_____

Thank you for helping us get to know your child.

Child(ren) Information	
Child's Name	Date of Birth

Illness: In order to keep our children healthy, ill children with fever, vomiting, diarrhea or a communicable disease will not be permitted to remain at the center while they are sick. Please make alternate arrangements for your child when he/she is ill. We follow physician's recommendations on the length of time a child or staff member should remain at home after an illness. A child must stay home 24 hours after beginning medication, except in cases of ear-infection or non-contagious condition.

WHEN A CHILD BECOMES ILL AT THE CENTER

We will telephone you or contact your listed emergency contacts if you cannot be reached. Please let us know where you'll be on your parent class or work schedule, please update your schedule when there are changes.

When possible we will take ill children to our sick room behind the main office. Please come and get your child immediately after we call you. If your child is still at the center more than an hour after you've been contacted, a $15 per hour fee may be assessed.

IMPORTANT: Please keep your child's file up to date with phone numbers, offices where you can be found, your child's doctor and person to call in case of emergency.

Refunds or credits are NOT granted if a child does not attend due to illness

Children are not permitted to remain at the center with any of the following conditions:

1) Vomiting: two or more episodes in 24 hours
2) Rash, lice or nits. Body rash, especially with fever or itching
3) Diarrhea: 3 or more watery stools in 24 hours ***(Diapered children: one occurrence where stool is uncontained).***
4) Eye infection. Thick mucus or pus draining form the eye.
5) Sore throat with fever or swollen glands.
6) Unusually tired, pale, lack of appetite, confused, cranky or ***unable to participate in activities.***
7) Fever. Temperature of 100 degrees (F) or more (taken under the arm).

Other exclusions are listed in the Family Handbook, along with the return to care instructions. If you have questions or concerns, please ask an Administrative Team Member.

Medication: Prescription medications are administered by staff only with written permission from parents and/or physician. Prescriptions must be the original container and the consent must include the following:

- Child's first and last name
- Name of medication to give
- Reason for giving medication
- Amount of medication to give
- How to give the medication (route)
- How often to give the medication
- Start and stop dates
- Expected side effects
- How to store the medication consistent with directions on the medication label
- Child MUST have had the medication prior to use at the Children's Center

Please refer to the Family Handbook for more information on the medication policy and illnesses/conditions that can exclude a child from attending.

Parent/Guardian Signature	Date

Please update this form whenever there is a change in your schedule									
Child's Name					Semester	Fall	Spring	Summer	Year
Parent/Guardian Name							Daytime Phone		
Please provide your location during each specified time frame									
Day of Week	8-9am	9-10am	10-11am	11am-Noon	Noon-1pm	1-2pm	2-3pm	3-4pm	4-5pm
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									

Please update this form whenever there is a change in your schedule									
Child's Name					Semester	Fall	Spring	Summer	Year
Parent/Guardian Name							Daytime Phone		
Please provide your location during each specified time frame									
Day of Week	8-9am	9-10am	10-11am	11am-Noon	Noon-1pm	1-2pm	2-3pm	3-4pm	4-5pm
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									

OR- I am not a student:

My Work Hours are:_____ Department Reception Phone Number:_____

Additional contact information:_____

Health Care Packet

As a licensed child care program we are required to meet state licensing standards. By completing the following forms this ensures that WSUCC complies with licensing and helps our staff to provide excellent care for your child. If you have any questions about the forms, please let us know.

Health History (Required) - This form is required for all children enrolled at WSUCC. Please fill out all sections of the form. *In cases where a child is too young to have a dentist, write/mark "none at this time." If you are new to the area and have not established a primary care physician you may write in "none at this time", and update this information later.*

Certificate of Immunization Status (CIS) Form (Required)- This form is required for all children enrolled at WSUCC, it must be signed by a parent/guardian to be valid. Your Health Care Provider may be able to print this form for you from the Immunization Information System. This form must be updated with vaccinations that your child receives while in care, a print out from your Health Care Provider or a copy of the state vaccination record can be used to update the CIS Form.

If your child has an allergy or intolerance please complete the following forms:

Allergy/Intolerance Statement:- Please help us to comply and meet the health needs of your child by completing the Allergy/Intolerance Statement form. We need to know which items the child is allergic or intolerant to, the steps to take to treat an allergic reaction, and appropriate substitute foods to assure that the child's nutrition is not compromised. This form must be signed by your Health Care Provider and be updated whenever there is a change in your child's health care plan or at least annually.

Individual Health Plan for Allergic Reactions:- This form will give the WSUCC staff the necessary information to identify symptoms of an allergic reaction in your child and the steps your health care provider would like us to follow. This form must be signed by your Health Care Provider and be updated whenever there is a change in your child's health care plan or at least annually.

Allergy Medication Authorization Form:-If your child may require medication during an allergic reaction or the use of an EpiPen, please have your Health Care Provider fill out this form. Please make sure to check expiration dates on medications periodically and replace as necessary. *In the event it is necessary for the use of an EpiPen or other provided medication for an allergic reaction. A detailed medication record is kept on file and copies may be provided upon request.*

If your child has asthma please complete the following forms:

Asthma Individual Health Plan- Please help us to comply and meet the health needs of your child by completing the Asthma Individual Health Plan. In the event that your child experiences asthma symptoms we need to be informed on the actions to take to help relieve their symptoms. This form must be signed by your Health Care Provider and be updated whenever there is a change in your child's health care plan or at least annually. . *In the event it is necessary for the use of provided medications for an asthma symptoms, a detailed medication record is kept on file and copies may be provided upon request.*

All fields on this form are required by licensing do not skip! If a field does not apply please mark as NA.

Child's Name (First & Last):	Date of Birth:

In case of an Emergency whom should be contacted first:

Relationship to Child	Name	Cell Phone Number	Work Phone Number	Home Number

Physician or Medical Facility

Name of Primary Care Office	Address	Phone Number
☐ None locally established		
Name of Primary Care Physician:		
Date of Last Physical:		

Dentist

Name of Dentist Office	Address	Phone Number
☐ None		

Authorization for Medical Care

I hereby give permission that my child may be given emergency treatment to include first aid and CPR by a qualified child care staff member of WSUCC. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health when 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 emergency vehicle for treatment.

Parent/Guardian Signature	Date

Please indicate if your child has any of the following Medical Conditions:

☐ No Known Allergies
☐ Food Allergies **(Please fill out a Food Allergy/Intolerance Statement**
☐ Non-Food Allergies **(Please fill out an Allergy Individual Health Plan)**
☐ Asthma **(Please fill out an Asthma Individual Health Plan)**

Any checked in this section will also require additional paperwork

☐ Diabetes ☐ Epilepsy/Seizure Disorder ☐ Cerebral Palsy/Motor Disorder
☐ Emotional/Behavior Disorder ☐ Gastrointestinal or feeding concerns (including special diets)
☐ Autism Spectrum Disorder ☐ Identified with a Cognitive Delay or Learning Disability
☐ Other conditions requiring special care

Please list any medication that your child is currently taking

Name of Medication	Dosage	Reason for Medication	Side Effects

Please note that any medication that will need to be administered during care by a staff member will need a Medication Authorization form completed.

Additional Information that may be helpful to child care provider

Signature of Parent/Guardian	**Date**
Please Print Full Name (First & Last)	

Certificate of Immunization Status (CIS)

DOH 348-013 January 2015

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 Information System.

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
■ Recommended, but not required

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

Parent/Guardian Signature Required **Date**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

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)**				
	1			
■ **Tetanus, Diphtheria (Td)**				
	1			
	2			
● ***Haemophilus influenzae* type b (Hib)**				
	1			
	2			
	3			
	4			
■ **Influenza (flu, most recent)**				

Vaccine	Dose	Date		
		Month	Day	Year
● **Pneumococcal (PCV, PPSV)**				
	1			
	2			
	3			
	4			
	5			
◆ **Polio (IPV, OPV)**				
	1			
	2			
	3			
	4			
◆ **Measles, Mumps, Rubella (MMR)**				
	1			
	2			
◆ **Varicella (chickenpox)**				
	1			
	2			
■ **Hepatitis A (Hep A)**				
	1			
	2			
■ **Human Papillomavirus (HPV) – does not print from the IIS; write dates in by hand**				
	1			
	2			
	3			
■ **Meningococcal (MCV, MPSV)**				
	1			
	2			

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

1) ❑ Chickenpox disease verified by printout from the Immunization Information System (IIS)
Must be marked by printout (not by hand) to be valid.

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

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) **Date**

Printed Name:

3) ❑ Chickenpox disease verified by school staff from the Immunization Information System

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

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) **Date**

Printed Name:

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

#1 To print with information filled in: First, ask if your healthcare provider's office puts vaccination history 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 information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS**, and return it to school or child care. If your provider's office does not use the IIS, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

#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 ▶

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 had chickenpox (varicella) disease and not the vaccine, **use only one** of these three options to record this on the CIS:

1) ❑ If your child's CIS is printed directly from the IIS (by your healthcare provider or school), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the IIS printout (not by hand).

2) ❑ If your healthcare provider can verify that your child had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your provider, or 2B if your provider signs and dates in the space provided. Be sure your provider's full name is also printed.

3) ❑ If school staff access the IIS and see verification that your child had chickenpox, they will mark box 3.

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your healthcare provider fill in this box. Ask your provider 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**, and return to the school or child care.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	FluLaval	Flu	Ipol	IPV	PedvaxHIB	Hib	Twinrix (Twnrx)	Hep A + Hep B
Adacel	Tdap	FluMist	Flu	Infanrix	DTaP	Pentacel (Pntcl)	DTaP + Hib + IPV	Vaqta	Hep A
Afluria	Flu	Fluvirin	Flu	Kinrix (Knrx)	DTaP + IPV	Pneumovax	PPSV or PPV23	Varivax	Varicella
Boostrix	Tdap	Fluzone	Flu	Menactra	MCV or MCV4	Prevnar	PCV or PCV7 or PCV13		
Cervarix	HPV2	Gardasil	HPV4	MenHibrix (Mnhbrx)	Meningococcal C/Y-HIB-PRP	ProQuad (PrQd)	MMR + Varicella		
Daptacel	DTaP	Havrix	Hep A	Menomune	MPSV or MPSV4	Recombivax HB	Hep B		
Engerix-B	Hep B	Hiberix	Hib	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)		
Fluarix	Flu	HibTITER	Hib	Pediarix (Pdrx)	DTaP + Hep B + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
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 (IIV 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 call 711).

DOH 348-013 January 2015

Washington State Department of Health

VACCINES REQUIRED FOR CHILD CARE/PRESCHOOL ATTENDANCE

July 1, 2015 – June 30, 2016

	Hepatitis B	**DTaP** (Diphtheria, Tetanus, Pertussis)	**Hib** (*Haemophilus influenzae* type B)	**Polio**	**PCV** (Pneumococcal Conjugate)	**MMR** (Measles, Mumps, Rubella)	**Varicella** (Chickenpox)
By 3 Months (on or before last day of mo 2)	**2 doses** May get Dose 1 at birth and Dose 2 as early as 1 month of age	**1 dose**	**1 dose**	**1 dose**	**1 dose**	**Not given before 12 months of age**	**Not given before 12 months of age**
By 5 Months (on or before last day of mo 4)	**2 doses**	**2 doses**	**2 doses**	**2 doses** May get Dose 2 as early as 4 months of age	**2 doses**		
By 7 Months (on or before last day of mo 6)	**2 doses**	**3 doses** May get Dose 3 as early as 6 months of age	**3 doses**	**2 doses**	**3 doses**		
By 16 Months (on or before last day of mo 15)	**2 doses**	**3 doses**	**4 doses**	**2 doses**	**4 doses***	**1 dose** May get Dose 1 as early as 12 months of age	**1 dose** May get Dose 1 as early as 12 months of age **OR** **Healthcare provider verifies disease**
By 19 Months (on or before last day of mo 18)	**3 doses**	**4 doses** May get Dose 4 as early as 12 months as long as 6 months separate Dose 3 and Dose 4	**4 doses**	**3 doses**	**4 doses***	**1 dose**	**1 dose** **OR** **Healthcare provider verifies disease**
By 7 Years (on or before last day of year 6) **or by Kindergarten Entry**	**3 doses**	**5 doses**	**Not given after 5 years of age unless child has medical condition**	**4 doses**	**Not given after 5 years of age unless child has medical condition**	**2 doses**	**2 doses** **OR** **Healthcare provider verifies disease**

***Some children may get 5 total doses. A single supplemental dose of PCV13 is recommended, but not required, for all children aged 14–59 months who got 4 doses of PCV7.**

- School-aged children (K-12) in before and after-school programs must meet the immunization requirements for their grade in school.
- Find information on other vaccines recommended, but not required, for child care/preschool attendance: www.immunize.org/cdc/schedules/
- Review the Individual Vaccine Requirements Summary for more detailed information: www.doh.wa.gov/Immunization/schoolandchildcare/VaccineRequirements.aspx

Minimum Age & Interval for Valid Vaccine Doses

Vaccine	Dose #	Minimum Age	Minimum Interval Between Doses	Notes
Hepatitis B **(HepB)**	Dose 1	Birth	4 weeks between Dose 1 & 2	▪ The final dose in the series should be given at least 24 weeks of age.
	Dose 2	4 weeks	8 weeks between Dose 2 & 3	
	Dose 3	24 weeks	16 weeks between Dose 1 & 3	
Diphtheria, Tetanus, and Pertussis **(DTaP/DT)**	Dose 1	6 weeks	4 weeks between Dose 1 & 2	▪ Typical vaccine schedule: 2, 4, 6, and 15-18 months of age. ▪ Recommended: 6 months between Dose 3 and Dose 4, but at least 4 months minimum interval acceptable.
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	6 months between Dose 3 & 4	
	Dose 4	12 months	6 months between Dose 4 & 5	
	Dose 5	4 years	--	
Haemophilus influenzae type B **(Hib)**	Dose 1	6 weeks	4 weeks between Dose 1 & 2	▪ If all 3 doses of PedvaxHIB given, only need 3 doses total. ▪ Only one dose required if the dose given on or after 15 months of age. Review the Individual Vaccine Requirements Summary for minimum doses required: www.doh.wa.gov/Immunization/schoolandchildcare/VaccineRequirements.aspx
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	8 weeks between Dose 3 & 4	
	Dose 4	12 months	--	
Pneumococcal Conjugate **(PCV7 or PCV13)**	Dose 1	6 weeks	4 weeks between Dose 1 & 2	▪ A single supplemental dose of PCV13 recommended for all children 14–59 months of age who got 4 doses of PCV7. ▪ Only one dose required if the dose given on or after 24 months of age. Review the Individual Vaccine Requirements Summary for minimum doses required: www.doh.wa.gov/Immunization/schoolandchildcare/VaccineRequirements.aspx
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	8 weeks between Dose 3 & 4	
	Dose 4	12 months	--	
Polio **(IPV or OPV)**	Dose 1	6 weeks	4 weeks between Dose 1 & 2	▪ Three doses acceptable if child got Dose 3 on or after the 4th birthday.
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	6 months between Dose 3 & 4	
	Dose 4	4 years	--	
Measles, Mumps, and Rubella **(MMR or MMRV)**	Dose 1	12 months	4 weeks between Dose 1 & 2	▪ MMRV (MMR + varicella) may be used in place of separate MMR and varicella vaccines. ▪ Must get the same day as VAR **OR** at least 28 days apart. ▪ 4-day grace **DOES** apply between doses of the same live vaccine such as MMR/MMR or MMRV/MMRV. The 4 day grace period **DOES NOT** apply between Dose 1 and Dose 2 of different live vaccines, such as between MMR and Varicella or between MMR and live flu vaccine.
	Dose 2	13 months	--	
Varicella (chickenpox) **(VAR)**	Dose 1	12 months	3 months between Dose 1 & 2 (12 months through 12 years) 4 weeks between Dose 1 & 2 (13 years and older)	▪ Recommended: 3 months between varicella doses, but at least 28 days minimum interval acceptable. Minimum age of 13 months acceptable. ▪ Must get the same day as MMR **OR** at least 28 days apart. ▪ 4-day grace **DOES** apply between doses of the same live vaccine; **DOES NOT** apply between doses of different live vaccines.
	Dose 2	15 months	--	

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DOH 348-053 January 2015

WASHINGTON STATE UNIVERSITY | Children's Center

Dear Parents:

Our center does not charge separately for meal because it participates in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). This program pays centers for nutritious meal served to all children while in care.

How much does the center receive in payment for meals served to my child while in care?
The amount of payment received is based on the income status of the families in our center. We receive a higher payment for those families that are low-income.

How do you determine the income status of my family?
The information you provide on the enclosed Enrollment/Income-Eligibility Application determines the income status and payment level.

I'm not sure if my family income qualifies. How do I decide?
If your gross income (before deductions) is the same as or less than the amount on the line for your family size on the income guideline table below, the center is eligible for the higher payment for your child(ren). When self-employed, net income may be reported. Please complete and return the Enrollment/Income-Eligibility Application to our office as soon as possible.

Income Guideline
Reduced-Price Meal
Effective July 1, 2016-June 30, 2017

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	21,978	1,832	916	846	423
2	29,637	2,470	1,235	1,140	570
3	37,296	3,108	1,554	1,435	718
4	44,955	3,747	1,874	1,730	865
5	52,614	4,385	2,193	2,024	1,012
6	60,273	5,023	2,512	2,319	1,160
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
Each additional household member add:	7,696	642	321	296	148

If I received payment from DSHS for child care, should I complete these forms?
Yes. DSHS payments for child care do not qualify a family for the higher payment.

If my household income is greater than the income guidelines for reduced-priced meals, or if I chose not to report my income, what should I do?
You should complete Parts 1 and 5 and may write "above-scale" in Part 4.

If I choose not to report my household income, do I still need to return the Enrollment/Income-Eligibility Application?
Yes. If you choose not to fill out the income portion of the Enrollment/Income Eligibility Application (E/IEA), you must still complete Part 1, the "Children's Information" section, and Part 5. Federal

PO Box 64345, Pullman, WA 99164-3454
509-335-8847 | Fax: 509-335-7980

regulations require that all child care centers collect information on the normal days and hours child(ren) are expected to be in care and the expected meals to be received.

Is there another way for the center to receive the higher payment other than using my family income?
Yes. Your child(ren) may be eligible for the higher payment based on one of the following:

1. You receive Basic Food, Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservation (FDPIR) for any member of your household.
2. Your child is a foster child.

If a household member currently receives benefits from one of these programs, or I believe my family income would qualify my child, what should I do?
Complete the attached Enrollment/Income-Eligibility Application, following the directions on the form. There is a separate section for each way your child may qualify.

Will this information be kept confidential?
Yes. The information will be made available only to a limited number of our staff or employees of the Office of Superintendent of Public Instruction, U.S. Department of Agriculture, or the U.S. General Accounting Office when they are reviewing our program.

Will the center make menu substitutions for my child?
If your child has been determined by a doctor to be disabled, and the disability would prevent the child from eating the regular meals at the center, we will make any substitutions prescribed by the doctor at no extra charge.

What do I need to bring to the center if my child needs menu substitutions?
You must bring the doctor's note that prescribes the alternative foods needed and verifies special meals are needed due to the disability.

Whom should I contact if I have any questions?
Contact our office at (509) 335-8847.

Thank you for helping us provide healthy meals for your child.

Sincerely,

Heather Havey

Heather Havey
Director

Child and Adult Care Food Program
ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 - CHILDREN'S INFORMATION—Required for all children in care

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD, TANF, OR FDPIR—Only one household member receiving benefits must be listed in order to establish eligibility for all children in the household.

Name	Circle One	Case Number or Identification Number
	Basic Food TANF FDPIR	

PART 3 - FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children

PART 4 - TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2

List Names (First and Last) of everyone in your household, including foster children	Gross Income from Last Month (if None, Write "0") (or net income if self-employed)			
	Earnings from Work Before Deductions	Alimony, Child Support, Welfare	Retirement, Pensions, Social Security	Job Two or Any Other Income
1.				
2.				
3.				
4.				
5.				
6.				
7.				

PART 5 - SIGNATURE AND CERTIFICATION - REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) **If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the Social Security Number is not needed.**

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Signature of Adult	Date	Print Name of Adult Signing	☐ I do not have a Social Security Number
		Social Security Number (last four digits) XXX-XX-	

Address	City/State/Zip Code	Daytime Phone

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES—You are not required to answer this part.

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, gender, age, or disability.

Race:

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Multi-Racial

If you feel you have been discriminated against, you should write USDA, Director of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410.

PRIVACY ACT STATEMENT

The Richard B. Russell National School Lunch Act requires that, unless a household member's Basic Food, TANF, or FDPIR case number is provided or you are applying on behalf of a foster child, you must include the last four digits of the Social Security Number of the adult household member signing the application, or indicate that the household member does not have a Social Security Number. Provision of the last four digits of the Social Security Number is not mandatory, but if the last four digits of the Social Security Number is not provided or an indication is not made that the signer does not have a Social Security Number, the application cannot be approved in the free or reduced-price category. This notice must be brought to the attention of the household member whose last four digits of the Social Security Number is disclosed. The last four digits of the Social Security Number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a Basic Food or welfare office to determine current certification for receipt of Basic Food or TANF benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

CENTER USE ONLY

☐ Foster child(ren) have been identified on this form and qualify for the free category.

☐ Child(ren) on this form who are not foster children qualify as follows:

Check one:
- ☐ Free Category
- ☐ Reduced-Price Category
- ☐ Above-Scale Category

Total Monthly Income $_____

This form must be signed and dated by the institution's representative.

_____ _____

Signature of Institution's Representative | Date