MORGEN OWINGS ELEMENTARY SCHOOL
STUDENT INFORMATION RECORD

(PLEASE PRINT FIRMLY)

DATE ENTERED ____________

NAME ____________ MALE ____ FEMALE ____ GRADE ____

LEGAL NAME ____________ ____________ ____________
FIRST MIDDLE LAST

MAILING ADDRESS ____________ PHONE ____________

STREET ADDRESS ____________ BUS ROUTE ____________

BIRTHDATE ____________ (IF KINDERGARTEN PROOF OF DATE:) YES ☐ NO ☐

BIRTHPLACE ____________

ETHNIC CATEGORY (OPTIONAL) AMERICAN INDIAN ASIAN BLACK HISPANIC WHITE

SCHOOL LAST ATTENDED ____________

CIRCLE	LAST NAME	FIRST	M.I.	PLACE OF EMPLOYMENT	WORK PHONE
FATHER/STEPFATHER					
MOTHER/STEPMOTHER					
GUARDIAN					

IS CHILD LIVING WITH: BOTH PARENTS ☐ MOTHER ONLY ☐ FATHER ONLY ☐

OTHER: (NAME & RELATIONSHIP) ____________

WHO HAS LEGAL CUSTODY? ____________

SPECIAL VISITATION RIGHTS INFORMATION (DURING SCHOOL HOURS): ____________

BROTHERS/SISTERS OF STUDENT:

NAME ____________ AGE ____ GRADE ____ NAME ____________ AGE ____ GRADE ____

NAME ____________ AGE ____ GRADE ____ NAME ____________ AGE ____ GRADE ____

DOES STUDENT HAVE OR HAS HE/SHE HAD: NO YES DATE IF YES, PLEASE DESCRIBE

1. ASTHMA ALLERGY (FOOD, INSECT, POLLEN, DRUG, OTHER)........ ( ) ( ) ( ) ____________
2. CONVULSIONS, FAINTING, DIABETES........ ( ) ( ) ( ) ____________
3. ANY OTHER PROBLEM TO WHICH YOU WISH TO CALL SPECIAL ATTENTION... ( ) ( ) ( ) ____________
4. DOES STUDENT TAKE MEDICINE REGULARLY........ ( ) ( ) ( ) ____________

IF YES, WHAT MEDICATION? ____________ WHEN? ____________

WHOM MAY WE CALL IN A EMERGENCY IF UNABLE TO REACH PARENTS?

NAME ____________ PHONE ____________

NAME ____________ PHONE ____________

IN THE EVENT OF SERIOUS ILLNESS OR INJURY TO MY CHILD WHILE AT SCHOOL AND THE SCHOOL IS UNABLE TO CONTACT EITHER PARENT, DISTRICT STAFF HAVE MY PERMISSION TO SEEK MEDICAL ATTENTION FROM THE NEAREST PHYSICIAN.

SIGNATURE ____________ RELATIONSHIP ____________

DO YOU HAVE MEDICAL INSURANCE? ____________ NAME OF COMPANY ____________

FAMILY DOCTOR ____________ FAMILY DENTIST ____________

SCHOOL USE ONLY:

RECORDS REQUESTED ____________ PERMANENT RECORD ____________ HEALTH CARD ____________ LOCATOR ____________

MIGRANT INFORMED ____________ READING SPECIALIST INFORMED ____________

TEACHER ____________ ROOM NUMBER ____________ FACULTY NUMBER ____________

Morgen Owings Elementary

REQUEST FOR TRANSFER OF EDUCATION BETWEEN SCHOOLS

PLEASE INCLUDE:
- ____ Cumulative Records
- ____ Health Records
- ____ Confidential Records
- ____ Psychological Evaluations, Records & Reports
- ____ Discipline History
- ____ Unpaid Fines
- ____ Attendance History

Former School: ______________________________

Address: ______________________________

City: ______________ State: ____________ Zip: ________

Student Name ______________ Birthdate ____________ Grade ________

Student Name ______________ Birthdate ____________ Grade ________

Student Name ______________ Birthdate ____________ Grade ________

Student Name ______________ Birthdate ____________ Grade ________

Send records to:

Morgen Owings Elementary
ATTN: Student Records
P.O. Box 369
Chelan, WA 98816

I acknowledge notification of this transfer of records as required by the Family Educational Rights and Privacy Act of 1974 and understand that I have a right to receive a copy at my own expense, if requested, and have an opportunity for a hearing to challenge the content of the records. I understand that the information transferred will be treated in a confidential manner and will not be transmitted to a third party without my consent.

PARENT SIGNATURE ______________________ DATE ____________

CURRENT ADDRESS ______________________________

Revised 9/99

Home Language Survey
Washington State
Transitional Bilingual Instructional Program

Student's Name	Date
School	Grade
SSID	Gender

1. ____Yes ____No If yes, list language(s)	Is a language other than English spoken in the home? Language(s) most often used by : Father ____________ ____________ Mother ____________ ____________ Guardian ____________ ____________
2. ___ Yes ___ No If yes, list language(s)	Is your child's first language a language other than English? ____________ ____________

______________________________ ( ) ____________
Parent or Guardian's Name Phone Number

____
Address City Zip

____
Student's Country of Origin

______________________________ ____/____/____
Parent or Guardian's Signature Date

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.*
- *"Eligible student" means any student who meets the following two conditions:*
  - *(a) The primary language of the student must be other than English; and*
  - *(b) The student's English skills must be sufficiently deficient or absent to impair learning.*

IF THE ANSWER TO QUESTION <u>NUMBER TWO</u> ABOVE WAS "<u>YES</u>": REFER THE STUDENT FOR TESTING ON THE WASHINGTON LANGUAGE PROFICIENCY PLACEMENT TEST.

Please Complete the Following:

A. ______For how many months has the student attended school in the United States (grades K – 12) before enrolling in this district?

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 dominant language.

Encuesta sobre el idioma del hogar
Estado de Washington
Programa de enseñanza bilingüe de transición

Nombre del alumno	Fecha
Escuela	Grado
SSID	Sexo

1. ____Sí ____No Si es afirmativo, indique cuál(es) idioma(s)	¿En su hogar se habla otro idioma que no es inglés? Idioma(s) que habla con mayor frecuencia: El padre ____________ ____________ La madre ____________ ____________ El tutor ____________ ____________
2. ___ Sí ____ No Si es afirmativo, indique cuál(es) idioma(s)	¿El primer idioma de su hijo es otro idioma que no es inglés? ____________ ____________

______________________________ ( )____________
Nombre del padre o tutor Teléfono

____
Dirección Ciudad Código

____
País de origen del alumno

______________________________ ____/____/____
Firma del padre o tutor Fecha

De conformidad con WAC392-160-005.

- *"Idioma principal" significa el idioma que el alumno (no necesariamente los padres, tutores u otros) usa con más frecuencia) para comunicarse en su hogar.*
- *"Alumno que reúne los requisitos" significa un alumno que cumple con las siguientes condiciones:*
  - *(a) El principal idioma del alumno tiene que ser otro idioma que no es inglés y*
  - *(b) Los conocimientos de inglés del alumno deben ser tan deficientes o nulos que le afecta al aprendizaje.*

SI LA RESPUESTA A LA PREGUNTA **NÚMERO DOS** ANTERIOR FUE **"SÍ"**: REMITA AL ALUMNO A QUE LE HAGAN EL EXAMEN DE DOMINIO DEL INGLÉS DE WASHINGTON.

Conteste lo siguiente:

A.______¿Durante cuántos meses asistió el alumno a una escuela en Estados Unidos (grados K – 12) antes de inscribirse en este distrito?

B. ______¿Durante cuántos meses recibió el alumno educación formal fuera de los Estados Unidos en su idioma materno (equivalentes a los grados K – 12) antes de inscribirse en este distrito?

Guía:

- Un (1) año escolar = diez (10) meses.
- "Educación formal" no incluye escuelas en campamentos para refugiados ni otros programas no acreditados.
- "Idioma materno" significa el idioma dominante de la familia.

Special Programs Enrollment Form

Today's Date ________________ Student Name ______________________________

Student Date of Birth ______________ Student Grade Level ______ Medical Coupons (yes or no)

1. Has Your Child Ever Been in a (check below) — Has a Sibling Ever been in a (check below)

	Has Your Child Ever Been in a (check below)		Has a Sibling Ever been in a (check below)
	Special Education Class		Special Education Class
	Speech or Language Therapy		Speech or Language Therapy
	Occupational/Physical Therapy		Occupational/Physical Therapy
	Counseling		Counseling
	Gifted Program		Gifted Program
	Migrant Program		Migrant Program
	Bilingual Program		Bilingual Program
	E.C.E.A.P. or Headstart or E.P.I.C. Program		E.C.E.A.P. or Headstart or E.P.I.C. Program

2. Does your child have a current Individualized Education Program (IEP) at this time?

_____ Yes _____ No

3. Has your child ever been diagnosed having (check below):

	Attention Deficit Disorder		Hyperactivity
	Attention Deficit Disorder w/Hyperactivity		Learning disabilities
	Auditory or Visual Problems		Physical/Health Problems
	Autism or Asperger's Syndrome		Speech/Language Problems
	Developmental Delays		

Please specify, including who made diagnosis:

____

____

____

4. Does your child have social/emotional or behavior problems which affect his/her performance at school? Please explain:

____

____

____

5. Are there any other concerns or comments that you would like to share with us?

____

____

____

Forma de matriculación para el programa de educación especial

Fecha de hoy ________________ Nombre de estudiante ______________________________

Fecha de nacimiento del estudiante ____ Grado del estudiante ______ Cupón medico (Sí o No)

1. Alguna vez su hijo/a (pon techa a los que corresponda) alguna vez un hermano/a a (pon techa a los que corresponda)

	Alguna vez su hijo/a		Alguna vez un hermano/a
	Clase de educación especial		Clase de educación especial
	Logopedia o terapia en lenguaje		Logopedia o terapia en lenguaje
	ocupacional/ terapia física		ocupacional/ terapia física
	orientación		orientación
	Programa de niño dotado		Programa de niño dotado
	Programa mígrate		Programa mígrate
	Programa bilingüe		Programa bilingüe
	Programa de E.C.E.A.P. o Headstart o E.P.I.C.		Programa de E.C.E.A.P. o Headstart o E.P.I.C.

2. ¿Su hijo/a tiene un programa de educación individualizada (IEP) en este momento?

_____ Sí _____ No

3. Alguna vez su hija/o ha, sido diagnosticado con (Pon techa a los que corresponda):

	Trastorno por déficit de atención		hiperactividad
	Trastorno por déficit de atención con hiperactividad		deshabilitad de aprendizaje
	Problemas visuales o auditorio		Problemas físicas o de salud
	Síndrome de autismo o Asperger		Problemas de lenguaje o de hablar
	Retraso de desarrollo		

Por favor especifica, incluyendo quien hizo el diagnostico:

____

____

____

4. ¿Tiene su hijo problemas sociales/emocionales o de conducta que afectan el rendimiento en la escuela? Por favor explique:

____

____

____

5. ¿Hay alguna otra preocupación o comentario que le gustaría compartir con nosotros?

____

____

____

Reviewed by: Staff Signature	Date:	Is there an accompanying signed Certificate of Exemption on file? ☐ Yes ☐ No

Washington State Department of Health

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 ☐ 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: Staff initials indicating parent approval: ______ Parent Signature indicating approval: ______
☐ Parental Report ▶	**ONLY** acceptable for some grades. Write date or age child had disease:	

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.**