



**Inglemoor Cooperative Preschool**  
**REGISTRATION INSTRUCTIONS**  
**2012 - 2013**

Thank you for choosing to be a part of Inglemoor Cooperative Preschool! To avoid enrollment delays, please carefully complete your registration packet as per the instructions below. If you are enrolling more than one child, all forms must be completed for each child you are enrolling. If you have any questions, please feel free to contact the registrar at (425) 821-BEST or info@inglemoorcooperativepreschool.org.

1. Complete the Registration and Parent Contract forms. Note that each form has two pages.
2. Complete the Health and Safety Form. Note that the form has two pages.
3. Complete the Certificate of Immunization Status if you have your child's immunization records now. If you don't have the records, request them from your medical provider, complete the Certificate of Immunization status and submit to the registrar before the first day of school. Your child cannot attend ICP classes until the form is received. If you choose not to vaccinate, please complete the Exemption Form and have it signed by your physician.
4. Provide a photocopy of your driver's license and proof of automobile insurance on a separate page. This is an ICP insurance requirement.
5. Complete the Shoreline Community College Parent Education Application & Registration. We will enter your student number for you.
6. Staple everything together and attach your check, payable to ICP. Registration fees for the first child or twins are \$100; each additional sibling is \$50.
7. Place all forms and your check in the Registrar's box at ICP or mail them to:

Inglemoor Cooperative Preschool  
 at Inglewood Presbyterian Church  
 Attn. Registrar  
 7718 NE 141<sup>st</sup> Street  
 Bothell, WA 98011

**ICP CLASS SCHEDULE**

CLASS	AGE*	DAYS	TIME	MONTHLY TUITION**
Toddler	1-2	Thurs	11:30 to 1:15 p.m.	\$55
Pre-3	2-3	Mon/Wed	9:00 to 10:45 a.m.	\$95
3-4	3-4	Tues/Thurs/Fri	9:00 to 11:30 a.m.	\$130
Pre-K	4-5	Mon/Wed/Fri	10:45 to 1:15 p.m.	\$140
Multi-Age	3-5	Mon/Wed/Fri	12:45 to 3:10 p.m.	\$135

\*Child's minimum age by August 31.

\*\*Tuition includes Shoreline Community College tuition, parent education speaker fees, and excursion costs for your child. There is a 10% discount for a second and third sibling.



**Inglemoor Cooperative Preschool**

**REGISTRATION FORM**

School Year 20\_\_ to 20\_\_

Please complete the following information (note there are two pages).

**Class you are enrolling in (circle one):**    **Toddler**    **Pre 3**    **3-4**    **Pre-K**    **Multi Age**

\_\_\_\_\_  
Participating Parent's Name

\_\_\_\_\_  
Date of birth (optional)

\_\_\_\_\_  
Child's Name            M or F (circle one)

\_\_\_\_\_  
Date of birth (required)

\_\_\_\_\_  
Mailing Address

(    ) \_\_\_\_\_  
Home Phone

(    ) \_\_\_\_\_  
Cell phone

(    ) \_\_\_\_\_  
Work Phone (for emergencies)

\_\_\_\_\_  
Email

\_\_\_\_\_  
Nanny / Caregivers Name

(    ) \_\_\_\_\_  
Nanny Contact Phone

\_\_\_\_\_  
Nanny Email

**Names to be used at school if different from above:**

\_\_\_\_\_  
Parent

\_\_\_\_\_  
Child

\_\_\_\_\_  
Parent's current occupation

\_\_\_\_\_  
Former occupation (before children)

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Special interests, hobbies

\_\_\_\_\_  
Spouse's name

\_\_\_\_\_  
Spouse's occupation

\_\_\_\_\_  
Employer

(    ) \_\_\_\_\_  
Work phone

\_\_\_\_\_  
Special interests, hobbies

\_\_\_\_\_  
Other family members (please include sibling's ages)

Does your child have any medical conditions we should be aware of, such as life-threatening allergies?

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Do you have any other concerns or fears about your child participating in this school?

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What are the goals for you and your child in our school?

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Do you have any skills or other talents you'd like to share with the children in your class (i.e. art, music, dance)?

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If you are new to ICP, how did you hear about our school? If someone referred you, please indicate the name.

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Are you currently certified in child CPR or child First Aid? If so, what is the expiration date?

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## Inglemoor Cooperative Preschool

### PARENT CONTRACT

School Year 20\_\_\_\_ to 20\_\_\_\_

Inglemoor Cooperative Preschool (ICP) will provide a caring, quality preschool experience for \_\_\_\_\_ (enrolled child's name) in the \_\_\_\_\_ class. I understand this is a cooperative preschool with strong parental involvement, and I agree to the following parental obligations and requirements. Please initial each line.

- \_\_\_1. I understand once my child is enrolled, my registration fee is non-refundable.
- \_\_\_2. My tuition is \$\_\_\_\_\_ per month. I accept full responsibility for submitting tuition payments by the first of each month and will pay in a timely manner. I agree to pay a late fee if my tuition is not paid by the 5<sup>th</sup> of each month as per details outlined in the parent handbook. If an unanticipated financial hardship arises, I understand I may be eligible for a partial scholarship. Scholarships are kept confidential.
- \_\_\_3. I will attend my class orientation meeting for each enrolled child during the month of September, or a make-up orientation arranged by my class coordinator if I am enrolling after September.
- \_\_\_4. I will work in the classroom one day per week, per child enrolled. If I am unable to work, I will arrange for a substitute.
- \_\_\_5. I will provide a nutritious snack for children on a rotating basis. Additionally, I will prepare small group activities on a rotating basis (3-4, Pre-K and Multi-Age classes only) as noted on my class schedule.
- \_\_\_6. I will be responsible for helping the children in my contact group during transition times and other times as needed.
- \_\_\_7. I will attend Parent Education meetings as required by Shoreline Community College. These meetings provide parent education and an opportunity to discuss preschool business.
- \_\_\_8. I will help support the school's daily operations by performing a committee job or serving on the Board.
- \_\_\_9. I will provide one individual session of classroom cleaning and participate in one of three scheduled group classroom cleanings during the school year.
- \_\_\_10. I will meet or exceed my fundraising obligation of \$150 for one child enrolled (\$200 for multiple children enrolled), as outlined in the Parent Handbook and defined by the Fundraising Committee.

- \_\_\_11. If I decide to withdraw from the preschool, I will submit a Notice of Withdrawal Form to ICP at least two weeks prior to my last day of attendance. I will fulfill my financial obligations—the full tuition of the month in which I will be leaving and a prorated fundraising commitment—prior to my departure.
- \_\_\_12. My son/daughter, \_\_\_\_\_, is hereby granted permission to attend ICP-sponsored excursions. I understand I will receive advance notification of the excursion details.
- \_\_\_13. I have a valid driver's license and carry liability insurance on any vehicles used for transporting preschool children. Washington State law requires a minimum insurance coverage of \$25,000/\$50,000/\$10,000 Split Limit Liability (25K for single person injury/\$50K entire accident injury/\$10K property) **OR** \$60,000 Single Liability. However, Washington State Community Colleges recommend minimum liability limits of \$100,000 per person and \$300,000 per occurrence in effect while transporting preschool children to/from preschool functions.  
**If I do not have automobile insurance, I will not transport preschool children other than my own without written parental permission.**
- \_\_\_14. During the course of our school year, we may take photos and/or video of parents and children for various preschool and promotional uses. Photos and videos WILL NOT be used in the current year your child is enrolled at ICP, but they may be used in future years once your child is no longer enrolled. My initials give ICP permission to use these photos and videos as they deem necessary, including use of the materials on the ICP website.
- \_\_\_15. I agree to read the Parent Handbook and By-Laws (to be delivered at your class orientation meeting before the school year). I understand failure to comply with the above stated responsibilities may result in action being taken according to the Conflict Resolution Procedure outlined in the By-Laws.
- \_\_\_16. I recognize that as long as I am enrolled in this program, I am entitled to student services at Shoreline Community College and other facilities. Services may include free or reduced costs of admission to speakers, plays, concerts, counseling services and other performances.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

Comments or questions:  
\_\_\_\_\_  
\_\_\_\_\_



## Medical information

\_\_\_\_\_  
List any health problems/issues

\_\_\_\_\_  
Known allergies and severity (drugs, foods, etc)

\_\_\_\_\_  
Medications

\_\_\_\_\_  
Child's physician/clinic

\_\_\_\_\_  
Phone number including area code

### Check appropriate emergency contact and release instructions:

\_\_\_\_\_  
Retain at school and release to parent only

\_\_\_\_\_  
Persons other than parent who may pick up child if unable to reach parents

**1.** \_\_\_\_\_  
Name Relationship Phone including area code

\_\_\_\_\_  
Address

**2.** \_\_\_\_\_  
Name Relationship Phone including area code

\_\_\_\_\_  
Address

## Health Insurance

\_\_\_\_\_  
Insurance company name

\_\_\_\_\_  
Phone including area code

\_\_\_\_\_  
Subscribers name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Policy number

\_\_\_\_\_  
Group number

### Authorizations:

In the event of an emergency, I hereby authorize that, \_\_\_\_\_, may be given emergency treatment by the co-op teacher or parent(s). In case of an accident or illness, attempts will be made to contact the parents before any kind of action is taken beyond necessary first aid except as necessary by a licensed physician for the stabilization of my child. My primary care physician or emergency contact person(s) listed above may authorize such care in my absence. **Initials** \_\_\_\_\_

I give permission for my child to attend cooperative preschool field trips (parents will be notified in advance of all field trips.) **Initials** \_\_\_\_\_

I certify that the above information is correct and verifiable. I also agree to notify the school Health and Safety committee if any of the above information is to change throughout the school year.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

<b>Office Use Only:</b>	
Reviewed by: _____	Date: _____
Signed Cert. of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

<b>Child's Last Name:</b> _____	<b>First Name:</b> _____	<b>Middle Initial:</b> _____	<b>Birthdate (mm/dd/yyyy):</b> _____	<b>Sex:</b> _____	<b>I certify that the information provided on this form is correct and verifiable.</b>
Symbols below: ◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only				<b>Parent/Guardian Name (please print):</b> _____	

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

Vaccine	Dose	Date					
		Month	Day	Year			
<b>◆ Polio (IPV, OPV)</b>							
	1						
	2						
	3						
	4						
<b>Influenza (flu, most recent)</b>							
<b>◆ Measles, Mumps, Rubella (MMR)</b>							
	1						
	2						
<b>◆ Varicella (chickenpox) or verify disease 1-4 ▶</b>							
	1						
	2						
<b>Hepatitis A (Hep A)</b>							
	1						
	2						
<b>Meningococcal (MCV, MPSV)</b>							
	1						
<b>Human Papillomavirus (HPV)</b>							
	1						
	2						
	3						
<b>Office Use Only: Immunization information updated and verified with parent/guardian permission:</b>							
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.**

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	_____
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	_____

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):

**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
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>				
DTaP	<b>1</b>	01	12	2011
DTaP	<b>2</b>	03	20	2011
DTaP	<b>3</b>	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.

Vaccine Trade Names in alphabetical order									
(For updated lists, visit <a href="http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf">http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf</a> )									
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 (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menaetra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqa	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrel)	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 <a href="http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf">http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf</a> )							
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	<i>Haemophilus influenzae</i> type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vaccine	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

2010-01-13 05:10

# Certificate of Exemption

## For School, Child Care and Preschool Immunization Requirements<sup>1</sup>



**DIRECTIONS:** All exemptions must have a licensed health care provider sign & date Box 1 ('Provider Statement').<sup>2</sup> Exception: Box 1 is not required for religious exemptions when Box 2 ('Demonstration of Religious Membership') is completed. All exemptions must also have a parent/guardian sign & date Box 3 ('Parent/Guardian Statement').

<b>Child's Last Name:</b>	<b>First Name:</b>	<b>Middle Initial:</b>	<b>Birthdate (mm/dd/yyyy):</b>	<b>Sex:</b>	<b>Parent/Guardian Name (please print):</b>
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**Parent/Guardian, please choose the exemption(s) that apply to your child below.**

<input type="checkbox"/> <b>Temporary Medical Exemption</b> <input type="checkbox"/> <b>Permanent Medical Exemption</b> <hr/> Vaccine(s) _____ Until _____ Date (or Permanent) <hr/> Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP) <hr/> X _____ X _____ Signature of Licensed Health Care Provider Date	<input type="checkbox"/> <b>Personal/Philosophical Exemption (see Box 1)</b> <input type="checkbox"/> <b>Religious Exemption (see Box 1)</b> <input type="checkbox"/> <b>Religious Membership Exemption (see Box 2)</b> I do not want my child to get the following vaccine(s): <input type="checkbox"/> Diphtheria <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hib <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Pertussis (whooping cough) <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Polio <input type="checkbox"/> Rubella <input type="checkbox"/> Tetanus <input type="checkbox"/> Varicella (chickenpox) <input type="checkbox"/> Other (indicate): _____
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Box 1
<p><b>Provider Statement<sup>2</sup>:</b> "I, _____, am a qualified provider (MD, DO, ND, PA, ARNP) licensed under Title 18 RCW. I confirm that the parent or guardian signing in Box 3 (Parent/Guardian Statement) has received information on the benefits and risks of immunization to their child as a condition for exempting their child for medical, religious, personal, or philosophical reasons."                  X _____                  Signature of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)                  X _____                  Date</p>

Box 2
<p><b>Parent/Guardian Demonstration of Religious Membership:</b> "I am a member of a church or religious body whose beliefs or teachings do not allow for medical treatment from a health care practitioner. By supplying the information requested below, no further proof or signed provider statement in Box 1 is required for this religious exemption."                  X _____                  Name of Church or Religious Body                  X _____ X _____                  Signature of Parent or Guardian Date</p>

Box 3
<p><b>Parent/Guardian Statement:</b> "I certify that all the information provided on this certificate 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 <b>excluded</b> from school, child care, or preschool until the outbreak is over."                  X _____ X _____                  Signature of Parent or Guardian Date</p>

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

<sup>1</sup> RCW 28A.210.080-090 states that before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian 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 and a licensed health care provider.

<sup>2</sup> A letter may substitute for a signed 'Provider Statement' on this certificate. To be accepted, the letter must reference the child's name on this certificate, confirm that the child's parent or guardian got information on the risks and benefits of immunization to their child, and be signed by a licensed health care provider.



**Inglemoor Cooperative Preschool**  
**PROOF OF LICENSE AND INSURANCE**  
**School Year 20\_\_\_\_ to 20\_\_\_\_**

Please copy onto this page or another blank page a copy of your drivers license and auto insurance. This is a requirement of Shoreline Community College.

# Parent Education Application

**Annual Registration Form for Academic Year 20\_\_ to 20\_\_**

**Please type or print with a ballpoint pen.**

Student I.D. Number		Social Security Number		<b>IMPORTANT:</b> Your social security number is confidential and, under a federal law called the Family Educational Rights & Privacy Act, the college will protect it from unauthorized use and/or disclosure. In compliance with state/federal requirements, disclosure may be authorized for the purposes of state and federal financial aid, Hope/Lifetime Learning tax credits, academic transcripts, assessment or accountability research.	
Adult Student Last name		First name		Initial	
Address: number and street				Apt. number	
City, state and zip					
E-mail Address:					
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		Birth Date: Mo. _____ Day _____ Yr. _____			
List previous last names		Day phone number ( ) ( )		Evening phone number ( ) ( )	
U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If not U.S. citizen, what is your Visa status?</b> <input type="checkbox"/> Visitor <input type="checkbox"/> Temporary resident (Alien number _____ ) <input type="checkbox"/> International student (with F or M Visa) <input type="checkbox"/> Refugee/parolee or conditional entrant (Alien number _____ ) <input type="checkbox"/> Immigrant/permanent resident (Alien number _____ ) <input type="checkbox"/> Other (explain) _____				
Have you lived <u>continuously</u> in the state of Washington for the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Have you attended Shoreline Community College previously? <input type="checkbox"/> Yes <input type="checkbox"/> No Last date attended:					
Have you previously participated in the SCC Parent Education Co-Op Program? <input type="checkbox"/> Yes <input type="checkbox"/> No Last date you participated:					

**ETHNIC ORIGIN (providing this information is optional):**

**Are you of Spanish/Hispanic/Latino origin?**

No  
 Yes, Mexican, Mexican-American, Chicano (722)  
 Yes, Puerto Rican (727)  
 Yes, Cuban (709)  
 Yes, Other Spanish/Hispanic/Latino (please specify): \_\_\_\_\_

**Please mark one or more boxes to indicate what race you consider yourself to be:**

White (800)  African American (872)  American Indian (597)  
 Alaska Native (015)  Native Hawaiian (653)  Other Pacific Islander (681)  
 Vietnamese (619)  Filipino (608)  Chinese (605)  Korean (612)  
 Japanese (611)  Other Asian (621)  
 Other Race (please specify): \_\_\_\_\_

I certify that to the best of my knowledge all statements on this form are true.

**X**  
Applicant's signature \_\_\_\_\_ Today's date \_\_\_\_\_

INSTRUCTOR'S USE ONLY			
LINE #	COURSE	DAY & TIME	INSTRUCTOR

OFFICE USE ONLY		
DATE RECEIVED:	DATE REGISTERED:	BY: