

Spring 2010

Welcome! We are excited to have your child attend Mead High School. Please note: **all registration documents must be completed in full for the student to be registered for classes.**

- Request for Transfer of Educational Records (M.H.S. will mail this)
- Registration form (2 pages)
- Health Information and Emergency Medical Treatment form
- Washington State Immunization Record (obtain immunization dates by contacting the student's prior school. Immunization dates are required **at time** of registration.)
- Residency verification (see 2nd page of form, supporting documents are **required!**)
- Home Language Survey
- Federal Ethnicity form
- E-notify form
- Please provide an unofficial transcript and state assessment scores from your child's prior school.**

*Please return the fully completed forms to:
Mead Senior High School
Attn: Robin Anderson, Registrar
302 W. Hastings Rd.,
Spokane, WA 99218*

Thank you. We look forward to meeting with you and your child soon!

Mead High School Counselors:

Keith Browning (A-D)	KBrowning@mead.k12.wa.us	(590) 465-7025
Dave Vaughn (E-K)	DVaughn@mead.k12.wa.us	(509) 465-7030
Colleen Thornton (L-Ri)	CThornton@mead.k12.wa.us	(509) 465-7029
Mike Phillips (Ro-Z)	MikePhil@mead.k12.wa.us	(509) 465-7028

Registrar:

Robin Anderson	robina@mead.k12.wa.us	(509) 465-7027
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MEAD SENIOR HIGH SCHOOL

REQUEST FOR TRANSFER OF ALL EDUCATIONAL RECORDS BETWEEN SCHOOLS

TO: Previous school _____

Address _____

City _____ State _____ Zip Code _____

Student's Name _____

Birthdate _____

Grade _____

Parent/Guardian or Registrar Signature

Date _____

The above student has enrolled at Mead High School. Please forward complete cumulative file, including:

- official transcript
- health forms

- withdraw grades
- special education records

- SSID number

PLEASE SEND RECORDS TO:

STUDENT SERVICES
MEAD SENIOR HIGH SCHOOL
302 W. HASTINGS RD.
SPOKANE, WA 99218

Phone: (509) 465-7027

Fax: (509) 465-7191

Records Release Authorization: Parent consent is not required for transfer of records to another school where the student intends to enroll.
(Authority: 20 U.S.C. 123g(b)(1)(D)).



Registration Form

Required Office Use Only

Residency Code: _____
 Teacher: _____
 School: _____
 Student Number: _____
 Building Enter Date: _____
 District Enter Date: _____
 FTE: _____
 Grad Year: _____
 Student's Primary School? YES NO
 Immunization Complete? YES NO

Childs Legal Name: _____
 (Please Print) Last First Middle

Nickname or other name child goes by: _____

BIRTHDATE: _____ AGE: _____ GENDER: M F GRADE _____

Did your child attend preschool (Head Start, Early Start or private pre-kindergarten program)? YES NO

Is the student in Foster Care? Yes No (Please circle one)

Does the student qualify for McKinney/Vento status? Yes No
 (Currently in a transitional or temporary living situation i.e. doubled up, hotel, shelter etc... due to a change in personal or family finances)

Attended Mead Schools before? YES NO If yes, which school? _____ Year _____

Last school attended _____ City/State/Zip _____ School Year _____

HOME RESIDENCE

Household Description: Both Parents Mother Only Father Only Mother/Stepfather Father/Stepmother Guardian Agency Self Other
 (please circle one)

Parent/Guardian _____ Employer _____ Work Phone _____

Parent/Guardian _____ Employer _____ Work Phone _____

Home Phone _____ Unlisted? YES NO E-Mail _____

Parent Cell Phone _____ Cell is primary phone. YES NO Student Cell Phone _____

Address _____ City _____ ZIP _____

Mailing Address if different from listed above: _____

SECONDARY RESIDENCE (If Applicable)

Parent/Guardian _____ Employer _____ Work Phone _____

Parent/Guardian _____ Employer _____ Work Phone _____

Phone _____ Unlisted? YES NO E-Mail _____

Parent Cell Phone _____ Cell is primary phone. YES NO Student Cell Phone _____

Address _____ City _____ ZIP _____ Receive Mail Here? Y N

Mailing Address if different from listed above: _____

ADDITIONAL INFORMATION

Is there a JOINT CUSTODY OR PARENTING PLAN in effect? YES NO (If yes, plan must be on file with the school for enforcement)

Is there a RESTRAINING ORDER in effect? YES NO (If yes, legal papers must be on file with the school for enforcement.)

Has your child ever been SUSPENDED OR EXPELLED from school? YES NO SCHOOL _____ YR _____

Has your child ever qualified or been enrolled in a special education program? YES NO

If so please specify _____

Has your child ever qualified for or had a 504 plan? YES NO

Has your child ever participated in: ___TITLE ___LAP ___GIFTED ___ESL ___OTHER _____

Additional Information On Back....

Additional Information (continued)

PLEASE LIST ALL SIBLINGS ATTENDING MEAD SCHOOLS:

FIRST NAME	LAST NAME	SCHOOL	GRADE

I do not authorize my child's image to be used in district publications (newsletters and web pages.)

I do not authorize my child's "Directory Information" to be published in his/her school directory for distribution.

Please do not disclose my child's "Directory Information" except to school officials with legitimate educational purposes and certain others as specified by the Family Educational Rights and Privacy Act.

Emergency Contacts/Authorizations

Emergency Medical Authorization

Does your child have a LIFE-THREATENING ALLERGIC REACTION OR MEDICAL CONDITION? YES NO If so, describe:

Check here if any of the above health conditions concerning your child are life threatening. If so, State law requires that medication/treatment orders and a nursing care plan be in place before the student attends school (RCW 28A.210).

If it is necessary for your child to take medication at school, you must provide the school with the physician's written instruction and your written permission. Medication at school must be kept in its original container. No medication of any kind (prescription or non-prescription) will be given at school unless the above conditions are met.

I do not authorize emergency treatment of this child by staff of any hospital emergency room: _____
Please Initial

In case of illness/injury or other emergency, when household cannot be contacted, I authorize the School District to call one of the following:

Emergency Contact _____

PHONE () _____ ALT. PHONE () _____ Relationship _____

Emergency Contact _____

PHONE () _____ ALT. PHONE () _____ Relationship _____

In an emergency, I authorize the School District to release my child to the person(s) above: YES NO

Verification of Information

The information on this form is true and accurate as of this date. I understand that falsification of information to achieve enrollment or assignment may be cause for revocation of the child's enrollment or assignment to a school in the Mead Public Schools. I will notify the school each time there is a change in this information.

_____	_____
Signature of Parent or Legal Guardian	Date

Mead School District HEALTH INFORMATION AND EMERGENCY MEDICAL TREATMENT

Name _____ Legal Name _____ Birthdate _____ Grade _____
Last First M.I. If Different

Address _____ Zip _____ Home Phone _____ Teacher _____

Living With (circle one): Both Parents Mother Only Father Only Mother/Stepfather Father/Stepmother Guardian Agency Self

Father's Name _____ Work Place _____ Bus. Phone _____ Cell Phone _____

Mother's Name _____ Work Place _____ Bus. Phone _____ Cell Phone _____

PLEASE CIRCLE ANY LIFE-THREATENING CONDITIONS

RCW 28A.210 requires that students with life-threatening conditions must have physician orders and a nursing care plan before attending school. This information will be shared with school district staff needing to know in order to provide a healthy, safe environment.

ASTHMA	Severity (mild, moderate, severe): Medications Needed at School:
BLOOD or BLEEDING DISORDER	Diagnosis: Special Needs/Limitations:
HEART PROBLEM	Diagnosis: Severity/Limitations/Special Needs:
DIABETES Type I or II?	Medications/Special Needs:
BEHAVIOR RELATED PROBLEM: ADD, ADHD, Autism, Anxiety or other diagnosed mental health disorders	Diagnosis: Medications/Special Needs:
FOOD ALLERGY Life Threatening: Yes No	Food(s): Medications Needed at School:
DIGESTIVE DISORDER Colitis, food/lactose intolerance, celiac, etc.	Diagnosis and Severity:
INSECT STING ALLERGY Life Threatening or Large Local Reaction?	Medications Needed at School:
LATEX ALLERGY	Medications Needed at School/Special Needs:
SKIN PROBLEM Eczema, etc	Describe Problem: Special Needs:
MALIGNANCY/CANCER	Type: Special Needs:
NEUROLOGICAL PROBLEM Hydrocephalus, Cerebral Palsy, etc.	Type: Special Needs/Limitations:
ORTHOPEDIC PROBLEM Arthritis, etc	Diagnosis: Special Needs (wheelchair, crutches)/Limitations:
RESPIRATORY PROBLEM Cystic Fibrosis, etc	Diagnosis: Medications Needed at School:
SEIZURE DISORDER	Type: Medications:
URINARY/KIDNEY DISORDER	Diagnosis: Special Needs:
VISION or HEARING PROBLEM Impairment or Loss	Describe: Special Needs/Glasses/Contacts/Hearing Aids:
DRUG/MEDICATION ALLERGY	Name Medications:
OTHER DIAGNOSED HEALTH PROBLEMS Or any additional comments	Describe and List any Special Needs:

NOTE: If any medication is needed at school, please ask the school office for the appropriate forms.

In case of child's illness/injury when parent/guardian can't be contacted, the school is authorized to call one of the following:

Name _____ Phone _____ Alt. Phone _____ Relationship _____

Name _____ Phone _____ Alt. Phone _____ Relationship _____

IN CASE OF SERIOUS EMERGENCY WHEN FAMILY CAN'T BE CONTACTED, PLEASE NOTIFY:

Dr. _____ Phone _____ Dentist _____ Phone _____

I authorize emergency treatment of the above named child by physician or dentist or the nearest hospital emergency room.

Yes _____ No _____ Parent/Guardian Signature _____ Date _____

Please inform the school of any changes in your child's information throughout the school year. If more information needs to be added, please note it on an additional piece of paper and attach it to this form.



Reviewed by: _____ Date: _____
Staff Signature

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

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 completed 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	Vaccine	Dose	Date	Age
◆ Hepatitis B (Hep B)							
	1			Hepatitis A (Hep A)			
	2				1		
	3				2		
Hepatitis B (Hep B) Alternate schedule for teens							
	1			Meningococcal (MCV4, MPSV4)			
	2				1		
Rotavirus							
	1			Human Papillomavirus (HPV)			
	2				1		
	3				2		
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)							
	1				3		
	2			Other			
	3						
◆ Diphtheria, Tetanus, Pertussis (Tdap, Td)							
	1						
	2						
◆ Haemophilus influenzae type b (Hib)							
	1						
	2						
	3						
	4						
I certify that the information provided here is correct and verifiable.							
Signature of Parent or Guardian							Date
Licensed HCP Signature (MD, DO, ND, PA, ARNP) _____ Date _____ Either: initial with parent approval or get parent signature below: Staff initials indicating parent approval: _____ Parent Signature indicating approval: _____							

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

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	Vaqtia	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.

II. Residency

A. Verification of Joint Residency:

The person with whom the student lives and who claims custody of the student must attach proof of residency, dated within the last 45 days and must show parent, guardian or caregiver's legal name and street address.

PRINT FIRST AND LAST NAMES OF PERSON(S) providing proof of residency. I, declare under penalty of perjury, that the above named student lives at this address with me. I also agree to notify the school within two (2) weeks when residency has changed.

First Name

Last Name

Signature(s) of Person(s)

_____	_____	_____
_____	_____	_____

B. Proof of Residency:

If you own property in the county you reside, please attach:

1. A county Property Tax bill or a Mortgage Statement in your name showing residence property; and
2. A utility bill in your name for the current month showing the residence property address; and one of the items listed below:
 - a. Proof of residency from the County Registrar of Voters; or
 - b. Current vehicle registration showing residency property address; or
 - c. One other bill mailed to you at your residence address; or
 - d. A cancelled check in your name for the current month showing residence property address.
 - e. _____

If you rent property in which you reside, please attach;

1. Copy of the lease/rental agreement; and
2. A utility bill in your name showing residence property address or, if such service is included as part of the rental agreement, you must provide satisfactory evidence that is so included; and one of the items listed below:
 - a. Proof of residency from the county Registrar of Voters; or
 - b. Current vehicle registration showing residency property address; or
 - c. One other bill mailed to you at your residence address; or
 - d. A cancelled check in your name for the current month showing residence property address.
 - e. _____

If you are sharing a home with another individual or family, please attach;

1. The Residence Affidavit signed by the primary resident of the home and subscribed and sworn before a district school employee OR Notary Public.
2. A utility bill in your name showing residence property address or, if such service is included as part of the rental agreement, you must provide satisfactory evidence that it is so included; and one of the items listed below:
 - a. Proof of residency from the County Registrar of Voters; or
 - b. Current vehicle registration showing residency property address; or
 - c. One other bill mailed to you at your residence address; or
 - d. A cancelled check in your name for the current month showing residence property address.
 - e. _____

NOTE: If legal custody of a child is split between two parents, in addition to the documents listed above, you must also attach a certified copy of the court order (parenting agreement) identifying each parent's respective award of physical custody. You are responsible to immediately inform the school of any changes to the court order.



Home Language Survey
 Washington State
 Transitional Bilingual Instructional Program

Student's Name		Date
School		Grade
SSID		Gender
1. <input type="checkbox"/> Yes <input type="checkbox"/> No	Is a language other than English spoken in the home?	
If yes, list language(s)	Language(s) most often used by:	
	Father _____	
	Mother _____	
	Guardian _____	
2. <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your child's first language a language other than English?	
If yes, list language(s)	_____	
Parent or Guardian's Name		Phone Number
Address		City Zip
Student's Country of Origin		____/____/____
Parent or Guardian's Signature		Date
<p>Reference to WAC392-160-005.</p> <ul style="list-style-type: none"> • "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: <ul style="list-style-type: none"> (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 NUMBER TWO ABOVE WAS "YES": 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?
<p>Guidance:</p> <ul style="list-style-type: none"> • One (1) school year = ten (10) months. • "Formal education" does not include refugees camp schools or other unaccredited programs for children. • "Native Language" refers to the family's dominant language.

Mead Schools Ethnicity and Race Data Collection Form

Thank you for taking the time to complete this form and help us comply with new Federal mandates for race and ethnicity reporting. Please understand if you prefer not to report your student's race and ethnicity school staff members are required to assign an ethnicity and race designation to your child.

Note the two sections below. Each must be completed, permitting those of multi-ethnic backgrounds to be fully described. In the first, choose either Not Hispanic/Latino, OR, if your child is of Hispanic/Latino origin, choose one or more specific ethnicities from Section 1. Section 2 offers 58 non-Hispanic choices. You may claim as many as necessary to describe your child's race. If necessary, you may claim Hispanic ethnicity or ethnicities together with a race or races from Section 2.

Student Full Name	Date of Birth	Parent Signature
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SECTION 1. Is your child of Hispanic or Latino origin? (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> NOT HISPANIC/LATINO
<input type="checkbox"/> CUBAN
<input type="checkbox"/> DOMINICAN
<input type="checkbox"/> SPANIARD
<input type="checkbox"/> PUERTO RICAN | <input type="checkbox"/> MEXICAN/ MEXICAN AMERICAN/ CHICANO
<input type="checkbox"/> CENTRAL AMERICAN
<input type="checkbox"/> SOUTH AMERICAN
<input type="checkbox"/> LATIN AMERICAN
<input type="checkbox"/> OTHER HISPANIC/LATINO |
|--|--|

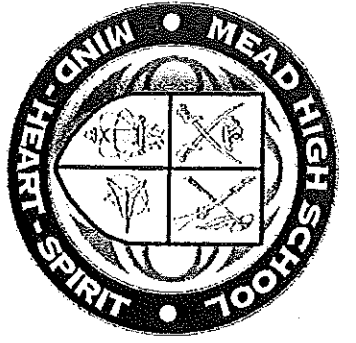
SECTION 2. What race(s) do you consider your child? (Check all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> AFRICAN AMERICAN/ BLACK

<input type="checkbox"/> WHITE

<input type="checkbox"/> ASIAN INDIAN
<input type="checkbox"/> CAMBODIAN
<input type="checkbox"/> CHINESE
<input type="checkbox"/> FILIPINO
<input type="checkbox"/> HMONG
<input type="checkbox"/> INDONESIAN
<input type="checkbox"/> JAPANESE
<input type="checkbox"/> KOREAN
<input type="checkbox"/> LAOTIAN
<input type="checkbox"/> MALAYSIAN
<input type="checkbox"/> PAKISTANI
<input type="checkbox"/> SINGAPOREAN
<input type="checkbox"/> TAIWANESE
<input type="checkbox"/> THAI
<input type="checkbox"/> VIETNAMESE
<input type="checkbox"/> OTHER ASIAN

<input type="checkbox"/> NATIVE HAWAIIAN
<input type="checkbox"/> FIJIAN
<input type="checkbox"/> GUAMANIAN or CHAMORRO
<input type="checkbox"/> MARIANA ISLANDER
<input type="checkbox"/> MELANESIAN
<input type="checkbox"/> MICRONESIAN
<input type="checkbox"/> SAMOAN
<input type="checkbox"/> TONGAN
<input type="checkbox"/> OTHER PACIFIC ISLANDER | <input type="checkbox"/> ALASKA NATIVE
<input type="checkbox"/> CHEHALIS
<input type="checkbox"/> COLVILLE
<input type="checkbox"/> COWLITZ
<input type="checkbox"/> HOH
<input type="checkbox"/> JAMESTOWN
<input type="checkbox"/> KALISPEL
<input type="checkbox"/> LOWER ELWHA
<input type="checkbox"/> LUMMI
<input type="checkbox"/> MAKAH
<input type="checkbox"/> MUCKLESHOOT
<input type="checkbox"/> NISQUALLY
<input type="checkbox"/> NOOKSACK
<input type="checkbox"/> PORT GAMBLE KLALLAM
<input type="checkbox"/> PUYALLUP
<input type="checkbox"/> QUILEUTE
<input type="checkbox"/> QUINAULT
<input type="checkbox"/> SAMISH
<input type="checkbox"/> SAUK-SUIATTLE
<input type="checkbox"/> SHOALWATER
<input type="checkbox"/> SKOKOMISH
<input type="checkbox"/> SNOQUALMIE
<input type="checkbox"/> SPOKANE
<input type="checkbox"/> SQUAXIN ISLAND
<input type="checkbox"/> STILLAGUAMISH
<input type="checkbox"/> SUQUAMISH
<input type="checkbox"/> SWINOMISH
<input type="checkbox"/> TULALIP
<input type="checkbox"/> YAKAMA
<input type="checkbox"/> OTHER WASHINGTON INDIAN
<input type="checkbox"/> OTHER AMERICAN INDIAN |
|---|--|



E-Notify
Registration

Student Name: _____

Parent Name: _____

E-Mail Address: _____
(Please print clearly)