Edmonds SCHOOL DISTRICT
Each student learning, every day!

P-134
Student Registration

Please Print Clearly

For Office Use Only
Received: _____ Time _____

School _____ Date _____ Time _____

STUDENT PERSONAL DATA

Student Name: LEGAL Last Name	LEGAL First Name	LEGAL Middle Name

Also or Previously Known as	Birthdate (Month/Day/Year)	Gender
		M F

Country of Birth (If outside of U.S.)	Grade Entering	When did your student first attend school in the USA? (Mo/Yr)	Student Cell Phone Number ( )

Has the student ever been previously enrolled in the Edmonds School District? ☐ YES ☐ NO

If so, which school(s)? _____

Have any of the following services EVER been provided to your student?
☐ ELL / ESL ☐ 504 Plan ☐ Highly Capable ☐ Other (Please specify):
☐ Special Education (IEP) ☐ Alternative School / Program

Will the student be SIMULTANEOUSLY attending another school while enrolled in the Edmonds School District?
☐ YES ☐ NO
If so, what other school will the student be enrolling in?

Has your student ever been
☐ Advanced – Grade(s):
☐ Retained – Grade(s):

Both questions must be completed.*

QUESTION 1. Is your child of Hispanic or Latino origin? (Check all that apply.)

☐ **NOT** Hispanic/Latino (10)
☐ Cuban (55)
☐ Dominican (60)
☐ Spaniard (65)
☐ Puerto Rican (70)
☐ Mexican/ Mexican American/ Chicano (30)
☐ Central American (75)
☐ South American (80)
☐ Latin American (85)
☐ Other Hispanic/Latino (90)

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

☐ African American/ Black (200)
☐ White(300)
☐ Asian Indian (505)
☐ Cambodian (507)
☐ Chinese (510)
☐ Filipino (520)
☐ Hmong (525)
☐ Indonesian (530)
☐ Japanese (535)
☐ Korean (540)
☐ Laotian (545)
☐ Malaysian (550)
☐ Pakistani (555)
☐ Singaporean (560)
☐ Taiwanese (565)
☐ Thai (570)
☐ Vietnamese (575)
☐ Other Asian (599)

☐ Native Hawaiian (605)
☐ Fijian (615)
☐ Guamanian or Chamorro (620)
☐ Mariana Islander (625)
☐ Melanesian (630)
☐ Micronesian (632)
☐ Samoan (635)
☐ Tongan (640)
☐ Other Pacific Islander (699)

☐ Alaska Native (405)
☐ Chehalis (410)
☐ Colville (413)
☐ Cowlitz (416)
☐ Hoh (418)
☐ Jamestown (421)
☐ Kalispel (424)
☐ Lower Elwha (427)
☐ Lummi (430)
☐ Makah (433)

☐ Muckleshoot (436)
☐ Nisqually (439)
☐ Nooksack (442)
☐ Port Gamble Klallam (445)
☐ Puyallup (448)
☐ Quileute (451)
☐ Quinault (454)
☐ Samish (457)
☐ Sauk-suiattle (460)
☐ Shoalwater (463)
☐ Skokomish (466)
☐ Snoqualmie (469)
☐ Spokane (472)
☐ Squaxin Island (475)
☐ Stillaguamish (478)
☐ Suquamish (481)
☐ Swinomish (484)
☐ Tulalip (487)
☐ Upper Skagit (488)
☐ Yakama (490)

☐ Other Washington Indian (495)
☐ Other American Indian: The indigenous peoples of North, Central, South, or Latin America (those not choosing one of the federally recognized state tribes). (499)

Is the parent or grandparent a member of a federally recognized tribe?
☐ **Yes**
☐ **No**

* **The information, in both questions 1 and 2, is required to be in compliance with 2010 Federal and State Ethnicity Reporting Requirements.**

Student Name _____ **School** _____

Has either parent ever been employed by or is currently employed by the Edmonds School District? ☐ Yes ☐ No

If so, under what name? _____

Has either parent ever been a student in the Edmonds School Distrct? ☐ Yes ☐ No

If yes, which parent? ☐ Mother ☐ Father

PRIMARY HOUSEHOLD INFORMATION

A students primary residence is defined as the physical location where he/she lives for FOUR OR MORE nights per week

Parent / Guardian 1	LEGAL Last Name	LEGAL First Name	LEGAL Middle Name
	Relationship to Student	Birthdate (Month/Day/Year)	Email Address
	Home Phone ( )	Work Phone ( )	Cell Phone Number ( )
Parent / Guardian 2	LEGAL Last Name	LEGAL First Name	LEGAL Middle Name
	Relationship to Student	Birthdate (Month/Day/Year)	Email Address
	Home Phone ( )	Work Phone ( )	Cell Phone Number ( )

Please use ( ) _____ - _____ as the primary contact number. Is this number confidential? ☐Yes ☐No

Residential Address Street Apt / Unit City State & ZIP

Mailing Address *(If different than above)* Street Apt / Unit PO Box City State & ZIP

RESIDENCY VERIFICATION: *I affirm that the residency information provided on this form is true and accurate as of this date. I understand that falsification of an address, residence, or conditions of living arrangements, or the use of any other fraudulent means to obtain a school assignment shall be cause for revocation of this enrollment. Such falsification will also cause forfeiture of any future transfer rights through the highest grade level of the school. Proof of residency (PUD bill; homeowner's statement or insurance policy; lease or renter's statement or receipt of payment; renter's insurance policy) is required.*

HOMELESS STUDENTS: *If an eligible student is homeless, the district shall not require proof of residency or any other information regarding an address and shall enroll the student at the request of the student or parent/guardian. Students enrolled in a district program without legal residence may continue in that school until the end of the academic year.*

Parent Signature: _____

Date: _____

SIBLINGS (IF APPLICABLE)

Please list all siblings attending an Edmonds School District program

Name	Grade	School

Name	Grade	School

SECONDARY HOUSEHOLD INFORMATION (IF APPLICABLE)

Residence of non-custodial parents/guardians not living with the student OR location where the student lives LESS THAN FOUR nights per week

Parent / Guardian 1	LEGAL Last Name	LEGAL First Name	LEGAL Middle Name
	Relationship to Student	Birthdate (Month/Day/Year)	Email Address
	Home Phone ☐ Unlisted ( )	Work Phone ☐ Unlisted ( )	Cell Phone Number ☐Unlisted ( )
Parent / Guardian 2	LEGAL Last Name	LEGAL First Name	LEGAL Middle Name
	Relationship to Student	Birthdate (Month/Day/Year)	Email Address
	Home Phone ☐ Unlisted ( )	Work Phone ☐ Unlisted ( )	Cell Phone Number ☐Unlisted ( )

Residential Address Street Apt / Unit City State & ZIP

Mailing Address *(If different than above)* Street Apt / Unit PO Box City State & ZIP

Student Name _____ **School** _____

EMERGENCY CONTACT INFORMATION - Other Than Parents

In case of an emergency, we will always attempt to contact parents or guardians first. Please list local persons ***other than yourself*** *usually available during the school day who have agreed to care for and provide transportation for your student in an emergency situation or if they become ill or injured and you cannot be reached.*

Emergency Contact 1	LEGAL Last Name	LEGAL First Name	LEGAL Middle Name	
	Relationship to Student	Birthdate (Month/Day/Year)	Residential Street Address City State Zip	
	Home Phone ( )	Work Phone ( )	Cell Phone Number ( )	
Emergency Contact 2	LEGAL Last Name	LEGAL First Name	LEGAL Middle Name	
	Relationship to Student	Birthdate (Month/Day/Year)	Residential Street Address City State Zip	
	Home Phone ( )	Work Phone ( )	Cell Phone Number ( )	
Emergency Contact 3	LEGAL Last Name	LEGAL First Name	LEGAL Middle Name	
	Relationship to Student	Birthdate (Month/Day/Year)	Residential Street Address City State Zip	
	Home Phone ( )	Work Phone ( )	Cell Phone Number ( )	
Doctor	Last Name	First Name	Contact Phone Number ( )	
Preferred Hospital (Optional)		**Health Insurance Company & Policy Number (Optional)**		

DAYCARE INFORMATION KINDERGARTEN THROUGH 6TH GRADE ONLY

Does your student attend childcare? ☐ YES ☐ NO If so, please provide the following information.

Should daycare be listed as an emergency contact? ☐ YES ☐ NO

Please check the days your child will be attending childcare.

Before School: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Childcare Provider Name	Provider Address	Contact Phone Number ( )

After School: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Childcare Provider Name	Provider Address	Contact Phone Number ( )

EDUCATIONAL BACKGROUND

Please list ***all*** *schools the student has attended. Attach additional sheet if necessary.*

Most Current / Recent School	Grades Attended Entry Date: Withdrawal Date:	Location of School (City & State or Country)	Phone Number ( ) Fax Number ( )
Name of Previous	Grades Attended Entry Date: Withdrawal Date:	Location of School (City & State or Country)	Phone Number ( )
Name of Previous	Grades Attended Entry Date: Withdrawal Date:	Location of School (City & State or Country)	Phone Number ( )
Name of Previous	Grades Attended Entry Date: Withdrawal Date:	Location of School (City & State or Country)	Phone Number ( )
Name of Previous	Grades Attended Entry Date: Withdrawal Date:	Location of School (City & State or Country)	Phone Number ( )

Please Print Clearly

Student Name _____ **School** _____

HOME LANGUAGE SURVEY (Please respond in English)

Office Use Skyward Box

1. Language
2. Native
3. Home

If two languages are present, enter the language other than English.

STATE REQUIRED HOME LANGUAGE SURVEY - *This is for the student WAC392-160-005*

Questions 1-3 pertain to the student only.

1. What language does the student currently speak? ☐ English ☐ Other: _____
2. What language did your child first learn to speak? ☐ English ☐ Other: _____
3. What language does your child use the most at home? ☐ English ☐ Other: _____

"First Language" is the language your child learned when first beginning to talk. If the answer to **question 2 or 3** is a language **other than English**, your student will be given a **Washington State English Language Proficiency Placement Test.**

Questions 4-6 pertain to the parent only.

4. What language(s) do parent/guardians use the most when you speak to your child? ☐ English ☐ Other: _____

Parents' first language: _____

5. If available, do you need an interpreter (e.g.,for school meetings)? ☐ Yes ☐ No
6. If available, do you need official school materials to be translated? ☐ Yes ☐ No

Please indicate the **preferred language** if you marked **"yes"** to **questions 5 or 6**: _____

OFFICE: *Do not change Native or Home Language after initial enrollment, unless correcting English to a language other than English. Never change Native or Home Language from another language to English unless instructed to do so by the ELL Department.*

In accordance with Washington State Law RCW 28A.225.330, please answer the following questions. Attach additional sheets if necessary.

Does your student have any history of violent behavior? ☐ YES ☐ NO If so, please explain.

Does your student have any past, current, or pending suspension or expulsion from a current or previous school? ☐ YES ☐ NO If so, please explain.

Has your student officially withdrawn from his/her current or previous school? ☐ YES ☐ NO Date: _____

Is your student currently under Becca/Truancy Petition? ☐ YES ☐ NO If so, from which district?

ADDITIONAL INFORMATION

Please check one of the following if a student's parent or guardian is currently in the military: ☐ US Armed Forces active duty ☐ National Guard member ☐ More than one member of the Armed Forces/National Guard ☐ US Armed Forces reserves ☐ No affiliation

Do you reside in transitional housing? ☐ Yes ☐ No

Transitional housing may be defined as living with another person/family due to loss of housing or economic hardship; living in a motel/hotel or in an emergency or transitional shelter, or a location not designed for, or ordinarily used as a regular sleeping accommodation, or is the child awaiting/currently in foster care?) If you can answer yes to any of these questions, your child may qualify for services under the McKinney-Vento Act. **Please ask your school about registering for services.**

Is there a Court Order that restrains / curtails any parental rights? ☐ YES ☐ NO If so, please provide copy.

Is there a Restraining Order in effect? ☐ YES ☐ NO If so, please provide copy.

Please list and provide copies of any other legal documents that are pertinent to your student and his/her safety.

_____

_____

Please provide additional comments to assist us in caring for your student.

_____

_____

_____

SIGNATURE

I attest that the information herein is complete, true, and accurate, and may be verified with the appropriate institution(s). I understand that providing false information may be grounds for revocation of enrollment in the Edmonds School District.

X _____ _____

Parent / Legal Guardian Signature Date

Update your voter registration! The school office can assist you.

FOR OFFICE USE ONLY

Edmonds SCHOOL DISTRICT
Each student learning, every day!

P-134 Att
Student Health Registration

School:_____ Expected Start Date:_____

Student Name	Date of Birth	Gender	Grade

Parent/Guardian Name	Daytime Phone ( )	Email

Heathcare Provider Name Phone ( )	Dentist Name Phone ( )

Medical Insurance Information

The following information is important for your student's health and safety. It will be forwarded to the school nurse and shared on a need to know basis to provide a safe and healthy environment at school.

ALERT: The school must know of **LIFE THREATENING** conditions (such as severe allergies, asthma, diabetes, seizures, or other at-risk conditions). This requires a Life-Threatening Emergency Care Plan and any necessary medication, supplies, and provider orders to be in place before your student can attend school (per RCW 28A. 210.320).

Does your student have a LIFE-THREATENING HEALTH CONDITION? ☐No ☐Yes: _____

If your student has a LIFE THREATENING HEALTH CONDITION please fill out BOTH PAGES OF THIS FORM

STUDENT MEDICAL HISTORY

☐**ALLERGIC to:** _____
☐Mild
☐Moderate
☐Severe
☐**Needs Emergency med (Epi-pen, Auvi Q)**

☐**ASTHMA**
☐Mild
☐Moderate
☐Severe

☐**DIABETES**
☐Type 1
☐Type 2

☐**SEIZURES**
☐**Needs Emergency med (Diastat, Midazolam)**

☐**No Known Health Concerns**

☐ADD/ADHD
☐Alcohol/Drug use
☐Anxiety
☐Autism
☐Autoimmune Disorder
☐Blood Disorder
☐Bowel/Bladder Concerns
☐Cancer
☐Cerebral Palsy
☐Concussion Date:_____
☐Congenital Condition
☐Cystic Fibrosis
☐Dental
☐Depression
☐Dietary Restriction
☐Ear infections
☐Eating Disorder:_____
☐Food Intolerance:_____
☐Frequent nosebleeds

☐Headaches
☐Hearing Problems
☐Heart Condition
☐Kidney Condition
☐Mental Health Concern:
☐Menstrual Problems
☐Neurological Condition
☐Orthopedic Condition
☐Physical Disability
☐Serious Injury
☐Skin Condition:_____
☐Social/ Emotional/Behavioral
☐Vision Problems
☐Other:_____
☐Hospitalizations:_____
☐Surgeries:_____
☐Medications:_____

If you have checked any of the above medical conditions, please explain: _____

Is your student required to take medication/treatments during the school day?
☐NO ☐YES (requires written authorization signed by Health Care Provider)

Please explain: _____

Does your child wear: ☐glasses ☐contacts ☐hearing aids

_____
Signature of Parent/Guardian Date

Please fill out next page if applicable or mark N/A and initial. rev 1/17

ALLERGIES

What causes allergic reaction? _____

Date of most recent allergic reaction? _____

Describe allergic reaction: ☐Hives ☐Swelling of lips, mouth, tongue, throat ☐Difficulty breathing ☐Nausea, stomach cramps, vomiting, diarrhea

Did this allergic reaction require emergency care? ☐No ☐Yes (Please explain):_____

Allergy medications:

NAME	DOSE	HOW OFTEN

Has your student had allergy testing completed? ☐No ☐Yes (Where & When?): _____

ASTHMA

What causes asthma symptoms? ☐Respiratory Infections ☐Pollens/Molds ☐Exercise ☐Weather/temperature ☐Animals ☐Smoke ☐Poor air quality ☐Strong Odors/Perfumes

Date diagnosed with asthma:_____Health Care Provider who diagnosed student: _____

Asthma medications:

NAME	DOSE	HOW OFTEN

Does your student use a spacer/aero chamber with their inhaler? ☐No ☐Yes

Has your student needed oral steroids (ie: prednisone)? ☐No ☐Yes (When): _____

Has your student been to the hospital for asthma? ☐No ☐Yes (Please explain): _____

DIABETES

Date when diagnosed: _____ Medication: ☐Oral:_____☐Insulin (type): _____

Equipment: ☐Insulin Pen ☐Insulin Pump (type):_____☐CGM (type): _____

Can your student check their own BG (Blood Glucose) independently? ☐No ☐Yes

Can your student count carbs independently? ☐No ☐Yes

Can your student calculate their insulin doses independently? ☐No ☐Yes

Can your student self-administer insulin independently? ☐No ☐Yes

SEIZURES

Date of first seizure: Date of most recent seizure:

Frequency of seizures occur? ☐Once ☐Daily ☐Weekly ☐Monthly ☐Yearly

Type of seizures: _____

Seizure medications:

NAME	DOSE	HOW OFTEN

Has your student had a seizure that has required emergency care/medication? ☐No ☐Yes (When?): _____

(Please explain):_____

Please list any other health concerns not previously listed above: N/A ☐_____

_____

_____

_____

_____

Parent Initials_____

Edmonds SCHOOL DISTRICT
Each student learning, every day!

SS-518 (K-12)
Immunization Packet

TO: **Parents of Edmonds School District Students**
FROM: Educational Health Services Department

This **Certificate of Immunization Status** is be submitted **on or before the first day of school**.
Washington State Law (RCW 28A.210.060170) requires certification of immunization for all school children.
According to state law (246-105 WAC), a student may have incomplete or "conditional" immunization status; this will allow the student to temporarily attend school until a parent/guardian submits required immunization documents, within **30 days from the first day of school**.

The **minimum** immunization requirements for the school attendance are listed on this form.

1. **Complete the Certificate of Immunization Status** by:
   - Entering the month, day and year when each required dose of a vaccine was given. (If you do not know the specific day, the Health Services professional will assume the first of the month.)

   OR

   - **Notifying the school that a schedule of immunization has been started** and will be completed in accord with your health care provider's recommended schedule. Immunizations are available from your private health care provider or you may obtain them from:

     Community Health Center of Snohomish – Edmonds location
     23320 Hwy. 99 Edmonds, WA 98026
     Phone: 425-640-5500

   - Please contact the clinic for an appointment
   - Parent and/or Legal Guardian must accompany the child
   - DSHS/Medicaid recipients should go to their assigned provider for immunization (Bring records of your child's immunization to Community Health Center to assure that your child receives the correct vaccine.)

   - **Complete a Certificate of Exemption** (C.O.E.) **in addition to the Certification of Immunization**
     BE AWARE-- If there is an outbreak at school of any vaccine-preventable disease for which your student is exempted, your student will be excluded from school for the duration of the outbreak.

2. **Sign the certificate(s)** indicating your information is correct.

Please contact your child's school if you need further assistance in completing the certificate.

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

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 Washington Immunization Information System.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (MM/DD/YY)**:** **Sex:**

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**

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

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ **DTaP, DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ❑ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV, MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers 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.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations 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 immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). 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**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements**.

- ❑ If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
- ❑ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS**.

Reference guide for vaccine abbreviations in alphabetical order For updated list, 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	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	*Haemophilus influenzae* type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade tames in alphabetical order For updated list, 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	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

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 December 2016

VACCINES REQUIRED FOR SCHOOL ATTENDANCE, GRADES K-12
July 1, 2017 – June 30, 2018

VACCINE	Kindergarten - 6th Grade	7th - 10th Grade	11th - 12th Grade
Hepatitis B	**3 doses** Dose 3 must be given on or after 24 weeks of age		Dose 3 must be given on or after 4 months of age
Diphtheria, Tetanus, and Pertussis (DTaP/DT/Td/Tdap)	**5 doses** (4 doses only **IF** 4th dose given on or after 4th birthday) ***Plus*** **1 dose Tdap required for 6th-12th grade AND** on or after 11 years of age ***(see page 2 for more details)***		
Polio (IPV or OPV)	**4 doses** (3 doses only **IF** 3rd dose given on or after 4th birthday) • The final dose given on or after August 7, 2009, must be given on or after 4 years of age AND a minimum interval of 6 months from the previous dose.	**4 doses** (3 doses only **IF** 3rd dose given on or after 4th birthday)	
Measles, Mumps, and Rubella	**2 doses**		
Varicella	**2 doses** **OR** Healthcare provider verified disease		

- Look at the Minimum Age and Interval Table on page 2 for recommended minimum age and spacing information.
- Review the Individual Vaccine Requirements Summary for more detailed information: www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/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 (K-12th)	▪ 2 doses valid if adult Recombivax HB® given between ages 11 and 15 and doses separated by at least 4 months.
	Dose 2	4 weeks	8 weeks between Dose 2 & 3 (K-12th)	
	Dose 3	24 weeks 4 months	16 weeks between Dose 1 & 3 (K-10th) 12 weeks between Dose 1 & 3 (11th-12th)	
Diphtheria, Tetanus, and Pertussis **DTaP/DT**	Dose 1	6 weeks	4 weeks between Dose 1 & 2	▪ DTaP: for children through age 6. ▪ 6 month interval is recommended between Dose 3 and Dose 4, but minimum interval of 4 months is acceptable. ▪ Students 7-10 years of age not fully immunized with DTaP should get one Tdap followed by additional doses of Td if needed. ▪ DTaP given after age 7 counts for the Tdap dose; no Tdap required at 11-12 years of age.
	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	–	
Tetanus, Diphtheria, and Pertussis **Tdap**	Dose 1	10 years recommended. See notes for exceptions	–	▪ Tdap: for children 7 years of age or older. ▪ If no DTaP doses given before age 7, students must get Tdap followed by 2 doses of Td. ▪ Tdap given between 7-10 years of age is valid and meets the requirement. ▪ Can be given regardless of the interval between DTaP or Td.
Tetanus and Diphtheria **Td**	Dose 1	7 years	5 years	▪ Td: for children 7 years of age or older.
Polio **IPV or OPV**	Dose 1	6 weeks	4 weeks between Dose 1 & 2	▪ Not required for students 18 years and older. ▪ If 4 doses of OPV received, and all doses given before 4 years of age, one dose of IPV is required at 4 years and older. ▪ Please see Individual Vaccine Requirements Summary for more details: www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization/VaccineRequirements.aspx
	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**	Dose 1	12 months	4 weeks between Dose 1 & 2	▪ MMRV (MMR + varicella) may be used instead 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 and MMR. 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 minimum interval of 28 days acceptable. Minimum age of 13 months also 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	–	