Welcome to Spanaway Lake High School

Enrollment Checklist

Student Name:______________________Grade:__________ Birth date:_______________

Last School Attended:__________________________Date withdrawn:_______________

All documents and forms must be completed before enrollment can occur.

If you are transferring to Spanaway Lake from outside the Bethel School District, you may ask your former school to fax the needed information to (253) 683-5658.

Please complete ***All*** forms (including the immunization record) within this enrollment packet. In addition to these forms, you will need to collect information/documents from your previous school.

1. Items to be collected and turned in:

   Withdrawal form from last school attended (only if withdrew mid-year). **Required**

   School transcript – unofficial copy is permitted **Required**

   Immunization records **Required**
   A copy may be obtained from your last school attended. State law requires this form to be completed before enrollment.

   All WASL/HSPE or other state test scores **Required**

   Discipline records **Required**

   IEP – if special education student, please provide copy of most current IEP and evaluation.

2. After ALL PAPERWORK is completed enrollment can occur.

Main Office
253-683-5600

Counseling Office
253-683-5659

Attendance Office
253-683-5692

Registration Fax
253-683-5658

Spanaway Lake High School
Verification of Student History

Student Name: ______________________ **Birthdate:** ______________ **Grade:** _____

School Information

Last School Attended: ______________________________ City: ______________

Enrolled from: ____________________ to ____________________

Have you ever attended any Bethel Schools? _____ yes _____ no

If yes, where ____

Academic History

Does this student have a history of any of the following:	Yes	No
Placement in AP classes	☐	☐
Placement in Honors classes	☐	☐
Placement in Running Start	☐	☐
Placement in a special education program	☐	☐
Special accommodations for a 504 plan	☐	☐
Health conditions affecting student's educational needs	☐	☐
Deaf/Hard of Hearing	☐	☐
ESL – Native Language ____________________	☐	☐

Discipline History

Has this student ever been suspended from school?	☐	☐
From what school (s)? ____________________		
Has this student ever been expelled from school?	☐	☐
From what school (s)? ____________________		

Does this student have a conviction, adjudication, or diversion agreement related to any of the following:

Violent Offense	☐	☐
Assault	☐	☐
Sexual Offense	☐	☐
Harassment, extortion, or stalking	☐	☐
Drug Offense	☐	☐
Alcohol Offense	☐	☐
Other	☐	☐

Are you currently working with a probation/parole officer? _____ yes _____ no

Probation Officer Name: ______________________ Phone ______________

**** If you answered, "yes" to any of the above, please complete your "Explanation" on the backside.**

Release of Student Information

We receive many requests for the names and addresses of students. In almost each circumstance, we reject and refuse to give out student information. We do comply with requests from the branches of the military service and other agencies because their educational and vocation connection to the school system. Some requesting agencies/services: PTSA related activities, legislature requests, class rings, and graduation related items.

The Bethel School District has permission to release the name and address of my student to requesting agencies:

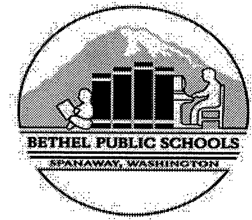
_____ yes _____ no Parent Signature: ______________________ Date: ____________

Printed name of person completing this form: ______________________________

Relationship to student: ☐ parent/guardian ☐ student (if over age of 18)

Completion of this form is required to enroll in Spanaway Lake High school. Failure to complete this form will result in the student not being enrolled. Deliberate falsification of any information on this form may result in the student's removal from the school/district and/or legal action.

Office of Superintendent of Public Instruction (OSPI)
Home Language Survey



Please print

Student Name		**Date**
Birth Date	**Gender**	**Grade**
Parent/Guardian Name __________	Relationship to Student __________	
If available, in what language would you prefer to receive communication from the school?		__________
Did your child receive English language development support through the Transitional Bilingual Instruction Program in the last school your child attended:		☐ **Yes** ☐ **No** ☐ **Don't Know**

1. In what city and country was your child born? a. Was YOUR CHILD born on a military installation outside of the US?	☐ Yes ☐ No
2. *What language did your child first learn to speak?	__________
3. *What language does YOUR CHILD use the most at home:	__________
4. What language(s) is used most in the home when speaking to your child?	__________
5. Has your child ever received ❖formal education outside of the United States? (Kindergarten – 12th grade) a. If yes, in what language(s) was instruction given? b. For how many months? ❖"Formal education" does not include refugee camps or other unaccredited programs for children.	☐ Yes ☐ No __________ __________
6. Has your child attended school in the United States before enrolling in Bethel School District? (Kindergarten – 12th grade) a. If yes, for how many months? One (1) school year = ten (10) months.	☐ Yes ☐ No __________
7. Do your student's grandparent(s) or parent(s) have a Native American tribal affiliation?	☐ Yes ☐ No

____
Signature of Parent/Guardian

____
Signature of Person Completing Form if other than Parent/Guardian

____
Printed Name of Person Completing Form if other than Parent/Guardian

BETHEL PUBLIC SCHOOLS
HEALTH HISTORY

Last Name	First Name	Middle Name	Birthdate	Gender

Physician	Date of last exam	Dentist	Date of last exam

Does the student have a life threatening condition? ☐ Yes ☐ No

If yes, please explain: ______________________________

____

What medications have been prescribed for this condition? ______________________________

____

ARE ANY OF THE FOLLOWING A PROBLEM FOR YOUR CHILD? (*Please circle and describe*)

Health problems at birth: ______________________________
Allergies: food, insect, pollen, drugs, other. Please specify: ______________________________
Blood: anemia, sickle cell disease, hemophilia ______________________________
Cancer ______________________________
Ears: hearing aids, infections, tubes, hearing loss ______________________________
Eyes: glasses, contacts, color blindness, other. Please explain: ______________________________
Gastrointestinal: ulcers, colitis, hepatitis, needs special bathroom privileges ______________________________
Genetic: Down Syndrome, cystic fibrosis, other. Please explain: ______________________________
Genitourinary: kidney or bladder infection, needs special bathroom privileges ______________________________
Heart: congenital, rheumatic, pacemaker, high blood pressure, restrictions ______________________________
Hospitalizations/operations ______________________________
Mental: ADHD, depression, bi-polar, other. Please explain: ______________________________
Metabolic: diabetes, thyroid, other. Please explain: ______________________________
Mouth: dental decay, orthodontia ______________________________
Neurological: seizures, meningitis, cerebral palsy ______________________________
Nose: fracture, nose bleeds ______________________________
Orthopedic: fracture, scoliosis, kyphosis ______________________________
Respiratory: asthma, bronchitis ______________________________
Serious injury ______________________________
Skin: acne, eczema ______________________________
Other (please explain): ______________________________
Disabilities: physical, mental, behavioral, learning, speech ______________________________

MEDICATION

Does your child take any medications routinely or for specific purposes such as allergies, ADHD, diabetes, epilepsy, etc? ☐ Yes ☐ No

If yes, is the medication taken at school ☐ at home ☐

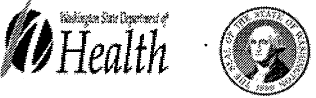
What is the name of the medication? ______________________________

In the event my child is injured or becomes ill and no responsible person from the home can be reached, I hereby designated the principal or the school's designated agent to do whatever is in the best interest of my child.

In the event my child is seriously injured, becomes seriously ill, or has a medical emergency, I hereby designate the principal or the school's designated agent to call 911 as the first emergency procedure.

Please indicate hospital preference(s): ______________________________

______________________________ ______________________________
Parent/Guardian Signature Date



Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Office Use Only:
Reviewed by: Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No

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

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (mm/dd/yyyy): **Sex:**

Symbols below: ◆ Required for School and Child Care/Preschool
● Required for Child Care/Preschool Only

Parent/Guardian Name (please print):

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

Parent/Guardian Signature Required **Date**

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

Vaccine	Dose	Date		
		Month	Day	Year
◆ **Polio (IPV, OPV)**				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ **Measles, Mumps, Rubella (MMR)**				
	1			
	2			
◆ **Varicella (chickenpox)** or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			

Office Use Only: Immunization information updated and verified with parent/guardian permission:

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.

- ❑ Diphtheria
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hib
- ❑ Measles
- ❑ Mumps
- ❑ Polio
- ❑ Rubella
- ❑ Tetanus
- ❑ Varicella
- ❑ Other: __________

Licensed health care provider (HCP) Signature **Date**
(MD, DO, ND, PA, ARNP)
HCP Printed Name: __________