Information Needed for Registration

Prospective **Kindergarten** students must be **five** years old by September 30, 2018.
Prospective **Pre-Kindergarten** students must be **four** years old by September 30, 2018.
All students must have the following documentation to submit a completed registration packet.

- **Completed Registration form with:**
- **The (Yellow) ZELC Pre-K Tuition Eligibility Form**
- **A Non-Refundable Registration Fee of $50 (Made Payable to ZELC).**
  - **Please put your child's name in the memo section of your check or money order.**

- Birth Certificate
- Social Security card
- Current immunization record
- Four current proofs of Zachary residence in the parent or legal guardian's name/address.
  * Provisional custody or custody by mandate is not accepted.

- **Documents must include:**
  - Mortgage or Lease agreement/rental contract on company letterhead with the landlord's name and phone number
  - Utility bill (City of Zachary – gas/water bill, showing name and address)
- **And at least 2 of the following:**
  - Entergy or DEMCO bill and Cable TV / Satellite bill or Telephone bill
  - Current Medical/Medicare or social security insurance card or Tax Assessor's bill
  - Homestead Exemption

- Both tuition and non-tuition Pre-Kindergarten spaces are limited and applications will be processed on a first come, first served basis.

- **Zachary Early Learning Center's monthly tuition from August through May is $450.00**
- **Families who wish to apply for non-tuition Pre-Kindergarten must provide proof of family income for an application to be considered.**

*Proof of income may include one of the following:

- Two current consecutive check stubs for EACH PARENT or CAREGIVER in the household.
- An official letter from your employer stating all of the following
  - Where parent/guardian is employed
  - Hourly rate of pay
  - The average number of hour(s) parent/guardian works per week.
- SNAP Card/Food Stamps and Case Detail Sheet: must include the child's name and valid effective dates.
- A statement from the Social Security Administration verifying that the child listed on the application is a recipient of SSI benefits, which must be accompanied by two current check stubs.
- Current foster care placement agreement from DCFS.
- Parents who are unemployed must submit a letter of support and income documentation from support source.

Further questions can be answered at 654-6011 for Pre-K students and 654-2786 for Kindergarten students.

Zachary Community Schools

School Registration

School	Date
SID#	Teacher
Method of Transportation	Bus #

Student Information

Social Security or ID assigned by previous LA District _____ Birth Certificate # _____

Last Name _____

First Name _____

Middle Name _____ Generation (Jr., III, etc) _____

Sex _____ Grade _____

Primary Ethnic: (choose one)
☐ 0 White ☐ 1 Black ☐ 2 Hispanic
☐ 3 Asian ☐ 4 Native American/Alaskan Native ☐ 5 Hawaiian/Pacific Islander

Secondary Ethnic: (if applicable)
☐ 0 White ☐ 1 Black ☐ 2 Hispanic
☐ 3 Asian ☐ 4 Native American/Alaskan Native ☐ 5 Hawaiian/Pacific Islander

Language spoken at home _____

Language first acquired by student _____

Language most often spoken by student _____

Birth Date _____ Place of Birth _____
Month Day Year

Date of Entry to U.S. (if not a natural born citizen) _____

Address Information

Physical Address _____

Apt.# _____ Apt. Complex _____ House# _____

City _____ Zip Code _____

Mailing Address _____

City _____ Zip Code _____

Home Telephone (225) _____

Names of Other ZCSB Students
living at the student's primary residence _____

_____

_____

Guardian Information

Father or Legal Guardian 1 Relationship to Student _____

Title _____ Last Name _____ First Name _____

Apt.# _____ Apt. Complex _____ House# _____

Street _____

City _____ Zip Code _____

Phone

Home # _____ Work # _____ Cell # _____

Email _____

Mother or Legal Guardian 2 Relationship to Student _____

Title _____ Last Name _____ First Name _____

Apt.# _____ Apt. Complex _____ House# _____

Street _____

City _____ Zip Code _____

Phone

Home # _____ Work # _____ Cell # _____

Email _____

Medical Information

Emergency Contact 1 Relationship to Student _____

Last Name _____ First Name _____

Phone _____ Address _____

Emergency Contact 2 Relationship to Student _____

Last Name _____ First Name _____

Phone _____ Address _____

Preferred

Hospital _____ Physician _____ Telephone _____

Allergies _____ Physical Handicaps _____

Additional Information

Please check any special education services your child has ever received

☐ Speech ☐ Special Education ☐ 504 ☐ Gifted Talented ☐ Other, please list

Has this student ever attended school in Zachary Community School System? _____

If yes, where? _____

Elementary aged students: Check all programs attended:

☐ Play School ☐ Nursery School ☐ Pre Kindergarten ☐ Kindergarten ☐ Headstart

Incoming Kindergarteners: Check all programs attended: ☐ Home (no Pre-K) ☐ Tribal Schools

☐ Public School PreK ☐ NonPublic PreK ☐ Licensed Childcare ☐ Head Start Programs

Please list the schools with the grades the student has attended

School _____ Grade _____ School _____ Grade _____

School _____ Grade _____ School _____ Grade _____

School _____ Grade _____ School _____ Grade _____

My signature attests to the accuracy of the information given on this form under penalty of law.

Zachary Community Schools

LOUISIANA STUDENT RESIDENCY QUESTIONNAIRE
(Form Must Be Included In School Enrollment Packet)

Date _____ District _____ School Name _____

Student Name: _____ SSN/ID#: _____ Gender: Male / Female

Address: _____ Telephone Number: _____

Last School Attended: _____ Current Grade: _____ Date of Birth: _____

Parent / Guardian / Adult caring for Student: _____ Relationship: _____

Disclaimer: This questionnaire is intended to address the McKinney-Vento Act. Your child may be eligible for additional educational services through Title I Part A, Title I Part C-Migrant, Individuals with Disabilities Education Act (IDEA) and/or Title IX, Part A, Federal McKinney-Vento Assistance Act, 42 U.S.C.11435. Eligibility can be determined by completing this questionnaire. It is illegal to knowingly make false statements on this form. If eligible, students are to be immediately enrolled in accordance with Bulletin 741, section 341.

1. ☐YES ☐ NO Is the student's address a temporary living arrangement? (Note: If this is a permanent living arrangement or the family owns or rents their home, sign under item 9 and submit form to school personnel.)
2. ☐YES ☐ NO Is the temporary living arrangement due to loss of housing or economic hardship?
3. ☐YES ☐ NO Does the student have a disability or receive any special education-related services? (Check one)
4. Where is the student currently living? (Check all that apply.)

☐ In an emergency/transitional shelter.
☐ Temporarily with another family because we cannot afford or find affordable housing.
☐ With an adult that is not a parent or legal guardian, or alone without an adult.
☐ In a vehicle of any kind, trailer park or campground without running water/electricity, abandoned building or substandard housing.
☐ Emergency Housing (i.e. FEMA Trailer or FEMA Rental Assistance)
☐ In a hotel/motel. ☐ Other specific information:_____

5. ☐ YES ☐ NO Does the student exhibit any behaviors that may interfere with his or her academic performance?
6. Would you like assistance with uniforms, student records, school supplies, transportation, other?
   (Describe: _____)
7. ☐ YES ☐ NO Migrant – Have you moved at time during the past three (3) years to seek temporary or seasonal work in agriculture (including Poultry processing, dairy, nursery, and timber) or fishing?
8. ☐ YES ☐ NO Does the student have siblings (brothers or sisters)? Note: Use back of page if more space is needed.
   Name _____ School _____ Grade _____ DOB _____
   Name _____ School _____ Grade _____ DOB _____
   Name _____ School _____ Grade _____ DOB _____
9. The undersigned certifies that the information provided above is accurate.

Print Parent/Guardian/Adult Caring for Student's Name | Signature | Date

(Area Code) Phone Number | Street Address | City | State | Zip Code

School Use Only: ☐ Free or Reduced Price Meals Form submitted/signed ☐ Copy Placed in Student's Cumulative Record

Homeless Liaison Use Only – *Check All that Apply*:

☐ Sheltered ☐ Doubled-Up ☐ Unsheltered/FEMA ☐ Hotel/Motel Unaccompanied Youth: ☐ YES ☐ NO

Print School Contact Name | Title | Signature | Date

06/2017

ZACHARY COMMUNITY SCHOOLS
SCHOOL NURSE DEPARTMENT

Welcome to Zachary Community Schools. We are excited that you have chosen our school system, which is one of the fastest growing, top-rated districts in the state, to educate your child.

In order to provide the best care possible for your child while at school, it is important for us to be aware of any medical conditions that might affect them during school hours or any condition that requires medication or possible nursing assistance (e.g. asthma, seizure disorder, diabetes, severe allergies, etc.). If your child does not have any medical issues or does not require any medication at school, we only need your signature on the "HIPAA Policy" form to be returned to school.

If your child has special medical needs, please complete and sign the enclosed forms. In addition, if your child requires medication at school, you may pick up the state mandated medication packet at your child's school or you may download these forms from the district website (www.zacharyschools.org) Go to top of the page to Divisions> Academics> Student Support Services> click ìSchool Nursesî link on right hand side of screen> Medication Packet, and complete and return them to school. A parent will have to bring the medication to school to be checked and logged in. **Please note that medication of any kind, including over-the-counter medication, may NEVER be sent to school with your child, and MUST be checked in by a parent along with the medication packet completed.**

Also, please ensure that your child's immunizations are up-to-date and that his/her school has an updated copy. This is required by Louisiana Department of Health and Hospitals and must be on file for your child to attend school.

Thank you in advance for your cooperation. We look forward to caring for your child.

Zachary Community School Nurses

HIPAA POLICY

NOTICE OF USE OF PERSONAL HEALTH INFORMATION

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. Please review it carefully:

We understand that any information we collect about your child and their health is personal. Keeping your child's health information private is one our most important responsibilities. We are committed to protecting their health information and following all laws about its use. You have the right to discuss your concerns with the system's Privacy Officer about how their health information is shared. The law says:

1. We must keep student's health information from others who do not need it.
2. You may ask us not to share certain health services information with others. However, occasionally certain situations prohibit us from complying with a request as such.

Your child may receive certain services from nurses, therapists, social workers, doctors, or other health-care related individuals. They may see, use, and share your child's health or medical information to determine any plan of treatment, diagnosis, or outcome of the said information as described in an Individualized Education Program (IEP) or other plan document. This use may cover such health services your child had before now or may have later.

We review such health services information and claims to make sure that you get quality services and that all laws regarding providing and paying for such health services are followed. We may also use the information to remind you about services or to inform you about treatment alternatives. In addition, we may also use the information to obtain payments for such services as a result of the Medicaid program. We must submit information that identifies you and your child, your child's diagnosis, and the type of services provided to your child for reimbursement by Medicaid.

We may share your health care information with teachers through health plans, with insurance companies and/or government programs in order for our school system to be reimbursed for such health care or medical services rendered during the school day.

As a general rule, you may request to see your child's health information. However, the request may not include psychotherapy notes or information being gathered for judicial proceedings. There may be legal reasons or safety concerns that would limit the amount of information that you may see. You may ask in writing to receive a copy of your child's health information. We may ask for payment for copying costs.

If you suspect some of your child's health information is wrong, you may ask in writing that we correct or amend it and you must provide the appropriate documentation, if applicable, from your child's physician in order to verify it.

You may request in the form of a signed 'Authorization of Release of Information' that any health information be sent to others who have received your child's health information previously from us. In addition, you may also request a comprehensive list of any recipients of such information. At any time, you may stop or limit the amount of information being shared by informing us in writing.

Note: A child 18-years old or older can give consent for his or her health information to be shared by signing an 'Authorization of Release of Information'.

In certain situations, we are mandated to abide by laws pertaining to sharing particular health information regarding your child, even if an 'Authorization of Release of Information' is not signed. We always report:

1. Contagious diseases, birth defects, and cancer;
2. Firearm injuries and other trauma events;
3. Reactions to problems with medicines or defective medical equipment;
4. To the police or other governmental agencies when required by law;
5. When a court orders us;
6. To the government to review how our programs are working;
7. To Worker's Compensation for work related injuries;
8. Date of birth and immunization information;
9. Abuse, neglect, and domestic violence, if related to child protection or vulnerable adults; or
10. To parents and other designated by law.

We may also share health care information for permitted research purposes and for matters concerning serious threats to public health or safety. Furthermore, if the health information falls within the FERPA definition of "education record", it will not be considered private health information under HIPAA, and therefore, will not be regulated by HIPAA.

If you have any questions about this notice of privacy rights or feel that such rights have been violated, you may contact:

Zachary Community School Board Office
(225) 658-4969 telephone
3755 Church Street, Zachary, LA 70791

You can also complain to the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. Your health care services will not be affected by any complaint made to the Zachary Community School Board, Secretary of Health and Human Services, or Office of Civil Rights.

You may ask for additional copies of our HIPAA policy at any time. The following link provides additional information regarding HIPAA and FERPA relevant to student health records.

http://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf

ZACHARY COMMUNITY SCHOOL BOARD

Dear Parent,

Attached you will find the Zachary Community School Board HIPAA policy Notice of Use of Personal Health Information. Please sign and return this form, so that we may maintain a record of your having received the information. Failure to return the signed form may result in a delay in servicing your child.

Thank you,

Zachary Community School Nurses

This is to certify that I have received and read a copy of the "Notice of Use of Personal Health Information".

_____

Parent's Signature

Names of children attending Zachary Community Schools and grades/homeroom teachers of each:

Name	Grade	Homeroom Teacher
Name	Grade	Homeroom Teacher
Name	Grade	Homeroom Teacher
Name	Grade	Homeroom Teacher
Name	Grade	Homeroom Teacher

If you have any questions, please feel free to contact your child's school.

STATE OF LOUISIANA
HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed. Use additional sheets, if necessary, for further explanation.

Student Name: Last First M.I.		Sex: M ❑ F ❑	DOB:	Grade:	School:
Student's Mailing Address:		City:		State:	Zip:
Student's Physical Address:		City:		State:	Zip:
Name of Mother/Legal Guardian	Home Phone	Work Phone		Cell Phone	Employer
Name of Father/Legal Guardian	Home Phone	Work Phone		Cell Phone	Employer
Name of pediatrician/primary care provider	Phone No	Name of medical specialists/clinics Phone No.			

Parents: Please notify the school nurse of any changes in the student's medical condition.

Parent/Legal Guardian Signature _____ Date_____

Please check the type of health insurance your child has: ❑ Private ❑ Medicaid/LaCHIP ❑ None

If your child does not have health insurance, would you like information on no-cost health insurance? ❑ Yes ❑ No

In case of emergency, if parent or legal guardian cannot be reached, **contact the following:**

Name Phone Number Cell Phone Number

My child has a medical, mental, or behavioral condition that may affect his/her school day: ❑ No ❑ Yes
(If yes, please complete Part 2)

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/Legal Guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms. **Parents are responsible to keep the school nurse informed regarding their child's health status.**

❑ **ALLERGIES**

Allergy Type:

❑ Food (list food(s) _____ ❑ Medication (list medication(s) _____

❑ Insect sting (list insect(s) _____

❑ Other (list) _____

Reactions- Date of last occurrence:

❑ Coughing Date: _____ ❑ Swelling Date: _____ ❑ Rash Date: _____

❑ Difficulty breathing Date: _____ ❑ Nausea Date: _____ ❑ Other _____

❑ Hives Date: _____ ❑ Wheezing Date: _____ _____

Currently prescribed medications and treatments:
❑Oral antihistamine (Benadryl, etc.) ❑Epi-pen ❑Other _____

❑ **ASTHMA**
Triggers (i.e., tobacco,dust, pets, pollen, etc.) (list) _____
Does your child experience asthma symptoms with exercise? ❑ No ❑ Yes
Symptoms: ❑ Chest tightness, discomfort, or pain ❑ Difficulty breathing ❑ Coughing ❑ Wheezing
❑ Other _____
Currently prescribed medications and treatments: _____

Date of last hospitalization related to asthma _____Date of last ER visit related to asthma _____

Does your child have a written asthma management plan? ❑No ❑Yes Is peak flow monitoring used? ❑ No ❑ Yes

❑ **DIABETES**
Currently prescribed medications and treatments: ❑ Insulin ❑ Syringe ❑ Pen ❑ Pump
❑ Blood sugar testing ❑ Glucagon ❑ Oral medication(s) List medication(s) _____
_____
Is special scheduling of lunch or Physical Education required? ❑No ❑Yes:

❑ **SEIZURE DISORDER**
Type of seizure: ❑ Absence (staring, unresponsive) ❑ Generalized Tonic-Clonic (Grand Mal/Convulsive)
❑ Complex Partial ❑ Other (explain) _____
Physical Education Restrictions: ❑ No ❑ Yes
Medication(s): ❑ No ❑ Yes List medication(s) _____
Date of last seizure _____ Length of seizure _____

❑ **OTHER HEALTH CONDITIONS** **Chicken Pox: Date of disease:** _____

❑ Anemia	❑ Digestive disorders	❑ Sickle Cell Disease
❑ ADD/ADHD	❑ Psychological	❑ Skin disorders
❑ Cancer	❑ Juvenile Rheumatoid Arthritis	❑ Speech problems
❑ Cerebral Palsy	❑ Hemophilia	❑ Other (explain)_____
❑ Cystic Fibrosis	❑ Heart condition	
❑ Depression	❑ Physical disability	

Physical Education Restrictions: ❑ No ❑ Yes (explain): _____
Medication(s): ❑ No ❑ Yes List medication(s) _____
_____

Special procedures required (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning): ❑ No ❑ Yes (explain): _____
_____

❑ **VISION CONDITIONS**_____ ❑ Contacts/glasses ❑ Other_____
❑ **HEARING CONDITIONS**_____ ❑ Hearing aid(s) ❑ Other: _____

❑ **ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**

Special adjustments of the school environment or schedule needed? ❑ No ❑Yes (explain):
(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)

_____

_____

Special adjustments to classroom or school facilities needed? ❑ No ❑ Yes (explain)
(i.e., temperature control, refrigeration/medication storage, availability of running water)

_____

_____

Special safety considerations required: ❑ No ❑ Yes (explain):
(i.e., precautions in lifting or positioning, transportation emergency plan, safety equipment, techniques for positioning or feeding)

_____

Special assistance with activities of daily living needed: ❑ No ❑ Yes (explain):
(i*.e., eating, toileting,walking)*

_____

Special diet required? ❑No ❑ Yes (explain)
(i.e., blended, soft, low salt, low fat, liquid supplement):_____

Are there anticipated frequent absences or hospitalizations? ❑ No ❑Yes (explain):

_____

PART 3: SCHOOL NURSE TO REVIEW if parent/legal guardian indicates medical condition.

Nurse Notes: _____

_____

_____

_____

_____

_____

_____

_____ _____

School Nurse Signature Date

MEDICAL HISTORY FORM
ZACHARY COMMUNITY SCHOOLS

Medical information is needed for the following student in order to determine if there are health impairments sufficient to warrant special education services. This information will also be utilized by the school nurse to provide health services. This form is to be completed by the Doctor. Please check appropriate behaviors and provide a simple explanation when indicated.

Name: _____ DOB: _____

Name of Parent(s)/Guardian: _____

Current Diagnosis, Medical Status, and Current Medication: _____
_____

Date Last Seen: _____ Return **to Clinic Date: _____**

Severity of Illness: ____ Mild ____ Moderate ____ Severe
Condition Causes:

- □ temporary or chronic lack of strength
- □ temporary or chronic lack of vitality
- □ temporary lack of alertness
- □ reduced efficiency in school work because of _____

Student is substantially limited in the following major life activity/activities: ____ caring for one's self ____ seeing ____ working ____ hearing _____ walking _____ performing manual tasks _____ breathing _____ speaking _____ learning _____ other major life activity (describe): _____

Recommendations For Student Integration Into The School Setting

Activity Restrictions/Limitations _____

Accommodations _____

Nutritional/Dietary _____

Special Procedures _____

Speech Therapy _____

Physical Therapy/ Occupational Therapy/ Adaptive Physical Education _____

Please check if you agree to your patient receiving OT/PT (will be considered orders for service for one year from date doctor signed)

- □ Occupational Therapy
- □ Physical Therapy

Physician's Signature: _____ Date: _____

Print Physician's Name: _____

Physician's Address: _____

Office #: _____ **Fax #**: _____

ZACHARY COMMUNITY SCHOOLS

PRE-KINDERGARTEN IMMUNIZATION

Under Louisiana Revised Statue 17:170, each student entering school within the state, "shall present satisfactory evidence of immunity to or immunization against vaccine-preventable diseases according to a schedule approved by the office of public health, Department of Health and Hospitals, or shall present evidence of an immunization program in progress."

Please submit an up-to date- copy of your child's immunization before school starts:

- **DTaP** – 5 Doses
- **IPV -** 4 Doses
- **MMR -** 2 Doses
- **VAR** – 2 Doses or history of having chicken pox
- **HBV**- 3 Doses
- **HIB** – 4 Doses

If you have any questions or concerns, please feel free to contact your child's school nurse.

For More Information:
Louisiana Department of Health and Hospitals: http://ldh.la.gov/index.cfm/form/67

Thank you,
Zachary Community Schools
Nursing Department

DEPARTMENT OF HEALTH AND HOSPITALS
Immunization Program

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF PUBLIC HEALTH

IMMUNIZATION SCHEDULE

2016 through 2017

Depending on the child's age, choose the appropriate initial set of immunizations.

RECOMMENDED SCHEDULE FOR IMMUNIZATION OF INFANTS AND CHILDREN

AGE	
Birth	HBV
2 Months[§]	DTaP, Hib, IPV, HBV, PCV[◊], RV
4 Months	DTaP, Hib, IPV,PCV, RV
6 Months	DTaP, Hib, IPV, HBV, PCV, Flu, RV
12-15 Months	DTaP, Hib, MMR, Var, PCV, HAV
18-23 Months	HAV
4 Years Of Age Or Prior To School Entry	DTaP, IPV, MMR, Var
11-12 Years	Tdap, MCV4, HPV∞ (VAR, MMR, HBV If needed)
16 year	MCV4

ACCELERATED SCHEDULE FOR CHILDREN STARTING IMMUNIZATIONS LATE

CHILDREN 4 MONTHS TO 7 YEARS OF AGE

1st Visit ‡	DTaP, Hib*,IPV,MMR,HBV,HAV, Var, Flu, PCV[◊]
2nd Visit (4 wks. after the 1st visit)	DTaP, Hib, HBV, IPV, PCV, Flu
3rd Visit (4 wks. after the 2nd visit)	DTaP, Hib, PCV
4th Visit (6 mos. after the 3rd visit)	DTaP, Hib, HBV, IPV, PCV,HAV
4 Years Of Age †	DTaP, IPV, MMR (Var if needed) Or Prior To School Entry

CHILDREN 7-18 YEARS OF AGE

1st Visit	Td, IPV, HBV, MMR, Var
2nd Visit (4 wks. after the 1st visit)	Td, IPV, HBV, MMR
3rd Visit (6 mos. after the 2nd visit)	Td, IPV, HBV
11-12 Years	Tdap, MCV4, HPV ∞ (Var, MMR,HBV,IPV if needed)
16 Years	MCV4

VACCINE ABBREVIATIONS

HBV HEPATITIS B VACCINE, HAV HEPATITIS A VACCINE, DTaP DIPHTHERIA - TETANUS - ACELLULAR PERTUSSIS VACCINE, Hib HAEMOPHILUS INFLUENZA TYPE B VACCINE, Td ADULT TYPE TETANUS AND DIPHTHERIA VACCINE , Tdap TETANUS AND DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE, IPV INACTIVATED POLIOVIRUS VACCINE, RV ROTAVIRUS VACCINE, FLU INFLUENZA VACCINE, MCV4 MENINGOCOCCAL CONJUGATE VACCINE, HPV HUMAN PAPILLOMAVIRUS VACCINE MMR MEASLES - MUMPS - RUBELLA VACCINE, VAR VARICELLA VACCINE, PCV PNEUMOCOCCAL CONJUGATE VACCINE.

Individuals with altered immunocompetence, due to disease or medication must be evaluated by a physician prior to vaccination.

THE SCHEDULE ABOVE AND THE FOLLOWING GUIDELINES ARE SUMMARIES, FOR MORE DETAILED INFORMATION ON EACH VACCINE, REFER TO THE MANUFACTURERS' PRODUCT INSERT OR VIST THE NATIONAL IMMUNIZATION PROGRAM WEB SITE AT WWW.CDC.GOV/VACCINES OR CALL THE NATIONAL IMMUNIZATION HOTLINE AT 800-232-2522 (ENGLISH) OR 800-232-0233 (SPANISH).

OFFICE USE ONLY: ____RETURNING STUDENT ____NEW ENROLLEE ____CHANGE OF ADDRESS REQUESTED

ZACHARY COMMUNITY SCHOOLS

Complete One Per Student

2018 – 2019 School Year

Zachary Community School Bus Service Request Form

Please NEATLY PRINT or Type All Information

Student's Name: _____.

I, (parent/guardian's name) _____, DO ( ) ** DO NOT( ) want bus service for my child for the 2018-19 school year. If you DO NOT want bus service for your child, please enter your name and your child's name on the lines above, sign on the signature line below*, and return this form to your child's school. If you DO WANT bus service for your child, please enter ALL requested information on this form and return to your child's school immediately. If a child does not need transportation in the morning or evening because of car pooling or other arrangements, please indicate so by writing "no ride" in the morning or evening box.

_____ _____

Parent/Guardian Signature* Sign Here **Today's Date**

Student's School for 2018 - 19:_____Student's Grade for 2018-19:_____

Parent/Guardian's Name:_____

Physical Home Address (No P.O. Boxes):_____

Town/City, Zip Code:_____

ENTIRE PHYSICAL ADDRESS WHERE CHILD WILL BE PICKED UP IN THE MORNING (NO P.O BOXES):

⬇

_____

ENTIRE PHYSICAL ADDRESS WHERE CHILD WILL BE DROPPED OFF IN THE EVENING (NO P.O. BOXES):

⬇

_____

If No Ride in AM or PM please place "No Ride" on appropriate Line. No response means student will be dropped at same location as picked up.

Home Phone Number:_____

Work Phone Number of Mother: _____Cell #:_____

Work Phone Number of Father: _____Cell#:_____

Other Emergency Names and Phone Numbers:_____

If your child receives Special Education services, does your child's I.E.P. indicate special transportation services be provided? _____Yes _____ NO

Thanks in Advance for Your Assistance Please Allow 2-3 Business Days

Zachary Early Childhood Network Application

Date of Application:_____Desired Start Date_____

Please fill in the form completely and accurately. All information will be kept confidential.

Student Information

Child's Full Name: _____ Birth Date: _____
Month Day Year

Gender: ☐ Male ☐ Female Preferred Language: _____

Primary Ethnic: (choose one)	☐ 0 White	☐ 1 Black	☐ 2 Hispanic
	☐ 3 Asian	☐ 4 Native American/Alaskan Native	☐ 5 Hawaiian/Pacific Islander
Secondary Ethnic: (if applicable)	☐ 0 White	☐ 1 Black	☐ 2 Hispanic
	☐ 3 Asian	☐ 4 Native American/Alaskan Native	☐ 5 Hawaiian/Pacific Islander

Site Preference

Please rank your site preferences 1-5 with 1 being your first choice

___Zachary Early Learning Center
___Bright Beginnings Child Development Center
___Just Like Home Learning Center
___Universal Children's Learning Academy, LLC
___Rising Starz Early Learning Center

Guardian Information

Father or Legal Guardian 1 Relationship to Student _____
Title _____ Last Name _____ First Name _____
Apt.# _____ Apt. Complex _____ House# _____
Street _____
City _____ Zip Code _____
Phone
Home # _____ Work # _____ Cell # _____
Email _____

Mother or Legal Guardian 2 Relationship to Student _____
Title _____ Last Name _____ First Name _____
Apt.# _____ Apt. Complex _____ House# _____
Street _____
City _____ Zip Code _____
Phone
Home # _____ Work # _____ Cell # _____
Email _____

Please Note: List only the people who are supported by the income of the parents or guardians of the child applying.
Family Size: Determined by including all persons living in the household who are supported by the income of the child's parents or guardians and related to the parents or guardians by blood, marriage or adoption.

_____# of Adults _____# of Children

Are you and your family: ☐ Homeless ☐ Foster Family

Do you receive:
☐ Medicaid ☐ Child Care Assistance
☐ Food Stamps ☐ SSI
☐ WIC ☐ FITAP/TANF

Does your child have identified disabilities?_____Yes_____No
Is your child in the Early Steps Program:_____Yes_____No

I certify that this information is true and correct._____Yes_____No Signature _____

I understand that if I deliberately misrepresent my family income or circumstances, my family may not be eligible for further services. In the event my child is not accepted into the program, my application may be released to local child care centers.
_____Yes_____No

*Proof of income required. See attached sheet
_____ I decline submitting income verification. I am responsible for all tuition and fees.

Signature_____ Date _____

Zachary Early Childhood Network
Proof of Income

Proof of Income may include one of the following:

_____ Two (2) current consecutive check stubs for EACH PARENT or CAREGIVER IN THE HOUSEHOLD.

_____ An official letter from your employer stating all of the following

- Where parent/guardian is employed
- Hourly rate of pay
- The average number of hour(s) parent/guardian works per week.

_____ SNAP Card/Food Stamps & case detail sheet: must include the child's name and valid effective dates.

_____ A statement from the Social Security Administration verifying that the child listed on the application is a recipient of SSI benefits, which must be accompanied by two current check stubs.

_____ Current foster care placement agreement from DCFS

_____ Parents who are unemployed must submit a letter of support and income documentation from support source.

_____ Other: CCAP, etc.