Information Required for ZCSD Student Registration

Prospective **Kindergarten** students must be **five** years old by September 30, 2020. Prospective **Pre-Kindergarten** students must be **four** years old by September 30, 2020. 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
- Birth Certificate
- Social Security card
- Current immunization record
- Current custody papers signed by a JUDGE showing domiciliary parent if parents are separated/divorced. NOTE: Provisional Custody by Mandate is not accepted.
- **RESIDENCY DOCUMENTS:**

IF THE PARENT IS THE HOMEOWNER OR LESSEE:

1. Mortgage or Lease Agreement/rental contract on company letterhead with the landlord's name and phone number
2. City of Zachary Gas/Water bill, showing name and address (current)
3. Electricity Bill – DEMCO/Entergy (current)
4. Drivers License of Parent (address must match residence address)

IF THE PARENT RESIDES WITH SOMEONE (DOUBLE UP):

1. Drivers License of Parent (address must match residence address)
2. Notarized Affidavit of Residency
3. Proof of termination of lease of prior residence as well as proof of termination of utilities **or** bill of sale from prior residence
4. <u>3 proofs in parent's name</u> (matching the residence address) made up of the following:
   - Paycheck
   - Bank statements: preprinted account statements from your bank. Bank statements printed from a home computer are not accepted.
   - Loan Payment Statements
   - Tax Statements (W2) – Forms can be requested from your employer
   - Voter Registration
   - Vehicle Registration
   - Court Letter
   - Correspondence from any government agency
   - Supervisor of School and Home Relations may accept other pieces of mail addressed to your name at the current residence

   **Students will be enrolled provisionally pending proofs required under #4. Parents have 30 days from enrollment to obtain and submit 3 proofs of residence to the Supervisor of School and Home Relations.*

   AND the following Documentation of the Homeowner/Lessee as follows:
5. Mortgage or Lease Agreement/rental contract on company letterhead with the landlord's name and phone number
6. Copy of Drivers License of Homeowner/Lessee (address must match residence address)
7. City of Zachary Gas/Water bill, showing name and address (current)
8. Electricity Bill – DEMCO/Entergy (current)

- 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 monthly tuition 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 consecutive check stubs for EACH PARENT or CAREGIVER in the household for current year.
- 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/Food Stamps: 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.
- **At time of registration, a non-refundable registration fee of $50 for Zachary Early Learning Center will apply to all applicants.**

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

3755 Church Street
Zachary, LA 70791
225.658.4969
Fax 225.658.5261
www.zacharyschools.org

RESIDENCY AFFIDAVIT

State of Louisiana

Parish of East Baton Rouge

BEFORE ME, the undersigned notary, personally came and appeared:

_____ (Full Name), called "Parent/Guardian," a person of the age of majority whose permanent mailing address is (Legal Custodian of Student):

_____
Street Number and Name City State Zip

Who did swear before me, upon his/her oath or affirmation, that he/she executed this Affidavit to formally acknowledge that:

_____(Student's Name) is residing with Parent/Guardian at

_____ called "Residence Address."
Street Number and Name City State Zip

Parent/Guardian further deposes and testifies that:

1. Parent/Guardian has been advised and is aware that this Affidavit is being provided to officials of the Zachary Community School Board for purposes of admitting a student(s) to the Zachary Community School System.
2. Parent/Guardian is advised and is aware that the making of intentionally false statements on this Affidavit may expose him/her and the residency owner being charged with filing false public records in violation of **L.A.R.S. 14:133** or other applicable laws of the State of Louisiana.
3. Parent/Guardian is advised that falsification of the information provided will result in the dismissal of the student from the Zachary Community School System.
4. With the foregoing understanding and awareness of the consequences of giving false information and filing false public records, Parent/Guardian attests that:
    a. The above name student(s) has/have no other residence/domicile in the State of Louisiana other than the Residence Address shown on this Affdavit.
    b. Parent/Guardian is the parent/legal guardian of _____(Student's Name), who is

3755 Church Street
Zachary, LA 70791
225.658.4969
Fax 225.658.5261
www.zacharyschools.org

residing with _____(Name of Homeowner) at the Residence Address. (**Homeowner must be present and sign where indicated that this information is correct.)**

c. If the Parent/Guardian's Residence Address changes, Parent/Guardian will visit the Zachary Community School Board Office located at 3755 Church Street, Zachary, LA 70791 within ten (10) days of the change of residence and complete a registration packet for a change of address and provide required residency documentation.

d. To enable residency verification, Parent/Guardian consents to an inspection and view of the residence herein identified as the student's residence to ensure that the information of the Affidavit to be true and correct.

e. All parties have carefully completed and read this Affidavit and attest to the truth of all the information provided.

This document is valid for one year. It will expire on the last day of the current school year.

SIGNATURES: **WITNESSES:**

_____ _____

PARENT/GUARDIAN

_____ _____

HOMEOWNER

SWORN TO AND SUBSCRIBED before me this _____ day of _____, 20___.

_____

NOTARY PUBLIC

NOTARY ID#_____

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 1-8 with 1 being your first choice

___Zachary Early Learning Center
___Bright Beginnings Child Development Center
___Just Like Home Childcare Center Three
___Universal Children's Learning Academy, LLC
___Rising Starz Early Learning Center
___Kidz Karousel-Zachary
___St. Patrick's Episcopal Day School
___Early Steps Child Development 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

Does your child have identified disabilities?_____Yes_____No

Is your child in the Early Steps Program:_____Yes_____No

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

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) consecutive check stubs for EACH PARENT or CAREGIVER IN THE HOUSEHOLD for current year

_____ 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/Food Stamps- 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.

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 _____

X _____

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

DEPARTMENT of EDUCATION
Louisiana Believes

Louisiana Student Residency Questionnaire Form

(Form Must Be Included In School Enrollment Packet)

Date: _____ LEA: _____ School Name:_____

Student Name: _____ 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 any 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

Print School Contact Name	Title	Signature	Date

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

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

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

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

ZACHARY COMMUNITY SCHOOLS BUS SERVICE REQUEST

Complete One Per Student

2020 – 2021 School Year

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 2020-21 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 2020 - 2021:_____Student's Grade for 2020-2021:_____

Parent/Guardian's Name:_____ _____

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

City:_____ Zip: _____

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

Principals Approval _____ Date _____

ZACHARY COMMUNITY SCHOOL BOARD

Parental Authorization to Publish Student Names, Videos, Photos, or Work

Dear Parent,

Your child's art, writing, video or picture may be considered for publication on the Zachary Community School Board website or other media outlets. The website is located on the Internet at **http://www.zacharyschools.org**. Please complete and return the following consent form. Forms will be filed at the school location.

The following information is considered private and will not be placed in any publication, except where described below.

Today's Date_____

School Year _____

Student's Name_____

Mailing Address_____

City, State, and Zipcode_____

Home Phone_____

Age_____

Grade_____

Teacher's Name_____

School_____

I give permission for my child's writing, picture, video or art, first name and last name initial, age, grade, and school's name to be published on the Zachary Community School Board website at http://www.zacharyschools.org or in other media outlets.

Parent's Signature_____

Teacher's Signature_____

I have written this composition myself. This work of art is my own original work.

Student's Signature_____

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

LOUISIANA DEPARTMENT OF HEALTH
OFFICE OF PUBLIC HEALTH

IMMUNIZATION SCHEDULE

2019

Depending on the child's age, choose the appropriate initial set of immunizations. High-risk children may require additional vaccines. Individuals with an altered immune system, due to disease or medication must be evaluated by a physician prior to vaccination. Routine annual influenza vaccination is recommended for all persons aged ≥6 months that do not have contraindications.

RECOMMENDED SCHEDULE FOR IMMUNIZATION OF INFANTS AND CHILDREN

AGE	
Birth	HepB
2 Months[§]	DTaP, Hib, IPV, HepB, PCV, RV
4 Months	DTaP, Hib, IPV, PCV, RV
6 Months	DTaP, Hib, IPV, HepB, PCV, RV, Flu
12-15 Months	DTaP, Hib, MMR, VAR, PCV, HepA
18-23 Months	HepA
4 Years of Age OR at School Entry	DTaP, IPV, MMR, VAR
11-12 Years	Tdap, MenACWY, HPV (VAR, MMR, HepA, HepB if needed)
16 Years	MenACWY, provider-patient discussion for MenB (HPV, VAR, MMR, HepA, HepB if needed)

ACCELERATED SCHEDULE FOR CHILDREN STARTING IMMUNIZATIONS LATE

CHILDREN 4 MONTHS TO 7 YEARS OF AGE

1st Visit[‡]	DTaP, Hib, IPV, HepA, HepB, MMR, VAR, PCV, Flu
2nd Visit (4 weeks after the 1st visit)	DTaP, Hib, IPV, HepB, PCV, Flu
3rd Visit (4 weeks after the 2nd visit)	DTaP, Hib, PCV
4th Visit HepB (6 months after the 3rd visit)	DTaP, Hib, IPV, PCV, HepA,
4 Years of Age[†] OR at School Entry	DTaP, IPV, MMR, VAR

CHILDREN 7 TO 18 YEARS OF AGE

1st Visit	Tdap, IPV, HepA, HepB, MMR, VAR
2nd Visit (4 weeks after the 1st visit)	Td, IPV, HepB, MMR
3rd Visit (6 months after the 2nd visit)	Td, IPV, HepA, HepB
11-12 Years	Tdap, MenACWY, HPV (IPV, VAR, MMR, HepB if needed)
16 Years	MenACWY, provider-patient discussio for MenB

VACCINE ABBREVIATIONS

DTaP DIPHTHERIA - TETANUS - ACELLULAR PERTUSSIS VACCINE, **Tdap** TETANUS AND DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE, **Td** ADULT TYPE TETANUS AND DIPHTHERIA VACCINE, **Flu** INFLUENZA VACCINE, **HepA** HEPATITIS A VACCINE, **HepB** HEPATITIS B VACCINE, **Hib** HAEMOPHILUS INFLUENZA TYPE B VACCINE, **HPV** HUMAN PAPILLOMAVIRUS VACCINE, **IPV** INACTIVATED POLIOVIRUS VACCINE, **MMR** MEASLES - MUMPS - RUBELLA VACCINE, **MenACWY** MENINGOCOCCAL CONJUGATE VACCINE, **MenB** MENINGOCOCCAL VACCINE, **PCV** PNEUMOCOCCAL CONJUGATE VACCINE, **RV** ROTAVIRUS VACCINE, **VAR** VARICELLA VACCINE.

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).

DTaP - DTaP vaccine is recommended and can be administered any time after 6 weeks through 6 years of age. The 4th dose of DTaP vaccine should be given at least 6 months after the 3rd dose. Pediatric DT (Diphtheria-Tetanus) should be substituted for DTaP when Pertussis vaccine is contraindicated. Persons aged 7 and older who are fully immunized with DTaP should receive a Tdap at 11- 12 years in place of Td booster.

Td/Tdap - Persons aged 7 years and older who are not fully immunized with DTaP vaccine should receive Tdap vaccine as 1 (preferably the first) dose in the catch-up series; if additional doses are needed, use Td vaccine. For children 7 through 10 years who receive a dose of Tdap as part of the catch-up series, an adolescent Tdap vaccine dose at age 11 through 12 years should NOT be administered. Td should be administered instead 10 years after the Tdap dose. Adolescents 13-18 years who missed the 11-12 year **Td/**Tdap booster should also receive a single dose of Tdap if they completed the recommended childhood DTaP series. No minimum interval required between giving doses of Td and Tdap. Subsequent routine Td boosters are recommended every 10 years.

Flu - Routine annual influenza vaccination is recommended for all children 6 months – 18 years. Two doses administered at least 1 month apart are recommended for children aged 6 months – 8 years who are receiving the influenza vaccine for the 1st time. Children 6 months through 8 years getting vaccinated for the first time, and those who have only previously gotten one dose of vaccine, should get two doses of vaccine. All children who have previously gotten two doses of vaccine (at any time) only need one dose of vaccine each season.

HepA – Routine Hepatitis A vaccination is recommended for all children 12 months through 18 years of age. The two doses in the series should be administered at least 6 months apart. If the interval between the first and second doses of Hepatitis A vaccine extends beyond 18 months, it is not necessary to repeat a dose.

HepB - Unimmunized infants should be given a first dose of Thimerosal-free HBV when first encountered, a second dose a minimum of 1 month later, and a third dose a minimum of 4 months after the first. Children aged 11-18 years of age who have not previously received 3 doses of Hepatitis B vaccine should be vaccinated. The 2nd dose should be administered at least 1 month after the 1st dose, and the 3rd dose should be administered at least 4 months after the 1st dose and at least 2 months after the 2nd dose. The minimum age for dose #3 is 6 months. Hepatitis B vaccine is routinely recommended for all children up to 19 years of age.

Hib - Hib vaccine can be administered any time DTaP vaccine is given. If PRP-OMP (PedvaxHIB [Merck]) is administered at 2 and 4 months of age, a dose at 6 months is not required. Children who are 7 months of age or older at the time they receive the 1st Hib vaccination should be immunized as follows: 1) Unimmunized infants 7-11 months of age should receive a 3-dose regimen. A first dose should be given now, a second dose 1 month later, and a 3rd dose after 12 months of age, at least 2 months after the previous dose. (2) Unimmunized children 12-13 months of age should receive a primary series of one dose and a booster at age 15 months. (3) Unimmunized children 15 months of age or older who have not yet reached their 5th birthday should receive 1 dose.

HPV – HPV vaccine is a 2 dose series for ages 9-14 years and a 3 dose series for ages 15-26 years. Administer the first dose of HPV vaccine between 11-12 years. Administer the second dose 6-12 months after the first dose. If the series was started at 15-26 years, then a three dose series is required: Four week minimum interval between dose 1 and dose 2. A minimum interval of 12 weeks required between dose 2 and dose 3. The 3rd dose should be given at least 24 weeks after the 1st dose. Adolescents aged 9-14 years who have already received two doses of HPV vaccine less than 5 months apart, require a third dose.

IPV - For infants, children and adolescents up to 18 years of age, the primary sequential series of IPV consists of four doses. The primary series is administered at 2 months, 4 months, 6-15 months and 4 years of age, or as age appropriate. A minimum of 6 months is required between the last two doses of IPV.

MMR - Two doses of MMR vaccine after 12 months of age are required with a minimum of 28 days separating the doses. If a child has received 2 doses of MMR vaccine after 12 months of age, another dose after the 4th birthday is not necessary. Children 11-18 years of age not previously immunized with MMR should receive two doses. Individuals with one dose of MMR must receive an additional MMR vaccination. Students in schools of higher learning must receive 2 doses of MMR prior to entry.

MenACWY - Meningococcal conjugate vaccine should be administered to all children at age 11-12 years, a booster dose on/after 16 years. The minimum interval between doses of MenACWY vaccine is 8 weeks. Only one (1) dose is needed if first dose given on or after age 16. This vaccine provides protection against meningococcal serogroups A, C, W, and Y, but not against serogroup B.

MenB – Teens age 16 through 18 years may be vaccinated routinely as an Advisory Committee on Immunization Practices Category B recommendation for provider-patient discussion. The 2 dose series protects against serogroup B meningococcal disease, but not serogroups A, C, W and Y. The two MenB vaccines are <u>not interchangeable</u>. The same vaccine product must be used for all doses in a series. Give 2 doses of either MenB vaccine: Bexsero, 1 month apart; Trumenba, 6 months apart.

PCV - All children should receive a 3 dose primary series and a booster if vaccination begun at ≤ 6 months of age; a 2 dose primary series and a booster if vaccination is begun between 7 and 11 months of age; a 2 dose series and no booster if vaccination is begun between 12 and 23 months of age. If vaccination is initiated at ≥ 24 months of age, the child should receive 1 dose of PCV. Children 24 through 59 months of age should receive a single dose of PCV13. Children with underlying medical conditions, a single supplemental PCV13 is recommended following primary series. High risk or presumed high risk for pneumococcal disease should be immunized with Polysaccharide Vaccine (PPSV) depending on the number of doses of PCV that they have received. PCV vaccination is required as part of the Daycare/Head Start Immunization Requirement for children less than 24 months of age.

RV - The first dose should be given between 6 and 14 weeks with the maximum age of first dose being 14 weeks 6 days of age**.** Maximum age for any dose is 8 months of age. Minimum interval between doses is 4 weeks. Monavalent RV1 is administered at 2 months and 4 months of age, a dose at 6 months is not required. Pentavalent RV5 is administered at 2 months, 4 months and 6 – 8 months. If RV brand is unknown a total of three (3) doses are needed.

VAR - All susceptible children who are at least 12 months old through 18 years of age should be vaccinated. Administer the second dose of varicella vaccine at age 4 – 6 years. Varicella vaccine may be administered prior to 4-6 years, provided that ≥ 3 months have elapsed since the first dose and both doses are administered at ≥ 12 months of age. Susceptible persons aged ≥ 12 years should receive two doses at least 1 month apart. Children with a history of typical chickenpox can be assumed to be immune to varicella. Serologic testing of such children is not warranted. Prior history of chickenpox is not a contraindication to varicella vaccination.

§ DTaP, IPV, HBV, PCV, RV and Hib can be administered as early as 6 weeks of age and simultaneously.

‡ Depending on the child's age, choose the appropriate initial set of immunizations. Sometimes a scheduled dose of vaccine may not be given on time. If this occurs, the dose should be given at the next visit. It is not necessary to restart the series of any vaccine due to extended intervals between doses.

† **LOUISIANA STATE LAW** requires prior to school entry: 2 doses of MMR, 3 HepB, 2 VAR and booster doses of DTaP and Polio vaccines on or after the 4th birthday and prior to school entry. A preschool dose is not necessary if the 4th dose of DTaP and the 3rd dose of IPV (provided it is administered at least 6 months after dose 2) are administered after the 4th birthday. Sixth graders (11 -12 years of age) are required: 1 Tdap, 2 VAR, 2 MMR, 3 HepB, 1 MenACWY. Effective 07/01/19, eleventh graders or 16 years of age will require 2 MenACWY. Entry for institutions of higher learning requires 2 doses of MMR, 1 Td/Tdap and 2 doses of MENACWY OR 1 dose, if first dose was given on or after age 16.

Four Day Grace Period: All vaccine doses administered less than or equal to four days before the required minimum interval or age shall be considered valid doses when evaluating a student record for compliance with immunization requirements for schools and child care entry. The Advisory Committee on Immunization Practices (ACIP) continues to recommend that vaccine doses not be given at intervals less than the minimum intervals or earlier than the minimum age.