



## Emergency Contact Information

Parent(s) or Guardian(s): \_\_\_\_\_

### INFORMATION/MEDIA RELEASE

Each year BCS publishes a family directory for parents and staff members. This directory includes the following information. Please check any that you would like omitted.  Home Telephone Number  Cell Numbers  Email Address  Home Address

\_\_\_\_\_ I do not want my child's  name,  photo,  video image disclosed in media, including Facebook and other social media, radio, TV, print media and school website. (please check those that apply.)

### PICK UP

Is there anyone you would like us to know about who **must never pick** up your child? \_\_\_\_\_

Name: \_\_\_\_\_

### EMERGENCY CONTACT NUMBERS

In the event the school needs to contact someone during the day (usually because a child is ill) and you cannot be reached,

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_



# STUDENT RECORD RELEASE

**Bellingham Christian School**  
1600 E. Sunset Dr. Bellingham, WA 98226 (360) 733-7303

NAME OF STUDENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

I authorize \_\_\_\_\_ to release the above information. (name of releasing school)

### INFORMATION TO BE RELEASED:

Scholastic Record, Health Record, Standardized Test Records, Special Education Test Results

### AUTHORIZATION STATEMENT AND SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN

Please mail this information to: **Bellingham Christian School**  
**1600 E. Sunset Dr.**  
**Bellingham, WA 98226**

(Needed for students entering first-eighth grade. Please complete copies of this form for each child applying.)



# ABUSE DISCLOSURE

BELLINGHAM CHRISTIAN SCHOOL

Background checks are conducted on all employees and volunteers of the school who will or may have unsupervised access to children less than sixteen years of age pursuant to the Child/Adult Abuse Information Act - Revised Code of Washington (RCW) 43.43.830-43.43.845.

An inquiry will be made based on the information you provide on the Request for Criminal History Information form on the next page.

Disclose whether you have:

- Been convicted of any crime;
- Had findings made against you in any civil adjudicative proceeding;
- Both a conviction and findings made against you.

You have a right to notification of the Washington State Patrol's response within ten days of receipt. Please contact the school office to obtain findings.

Signed: \_\_\_\_\_ Phone: \_\_\_\_\_

(Page one of two. Please complete copies of this form for each parent.)

# WASHINGTON STATE PATROL

Identification and Criminal History Section  
PO Box 42633, Olympia WA 98504-2633



## REQUEST FOR CRIMINAL HISTORY INFORMATION CHILD/ADULT ABUSE INFORMATION ACT RCW 43.43.830 THROUGH 43.43.845

<p><b>A REQUESTING AGENCY/ADDRESS</b></p> <p>Agency <u>Bellingham Christian School</u></p> <p>Attn _____</p> <p>Address <u>1100 E Sunset Dr</u></p> <p>City/State/Zip <u>Bellingham, WA 98226</u></p> <p>I certify this request is made pursuant to and for the purpose indicated.</p> <p><u>Kelli K Schmidt</u> _____ Authorized Signature Date</p> <p><u>Enrollment Coord.</u> (360) <u>733-7303</u> Title Area Code/Phone Number</p>	<p><b>B PURPOSE</b> Check appropriate box</p> <p><input checked="" type="checkbox"/> Educational School District (ESD)/School District Volunteer – no fee</p> <p><input type="checkbox"/> Non-Profit Business/Organization – no fee (Excluding Schools &amp; ESD's)</p> <p><input type="checkbox"/> Profit Business/Organization - \$17</p> <p><input type="checkbox"/> Adoptive Parent - \$17</p> <p><input type="checkbox"/> Receive background results electronically</p> <p>Email address _____</p> <p>Password _____ (must be at least 8 characters)</p> <p>Fees: Make payable to Washington State Patrol by check, money order, or business account.</p> <p>Notary letters certifying the results are available upon request. There is an additional \$10.00 processing fee per notary seal.</p> <p>_____ Notarized Letter(s)</p>
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**C APPLICANT OF INQUIRY** (Please provide as much information as possible; name and date of birth are mandatory.)

Applicant's Name: \_\_\_\_\_  
Last First Middle

Alias/Maiden Name(s): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_  
Month/Day/Year

Secondary dissemination of this criminal history record information response is prohibited unless in compliance with statute.

**D WASHINGTON STATE PATROL IDENTIFICATION & CRIMINAL HISTORY SECTION**

As of this date, the applicant named below has no record pursuant to RCW 43.43.830 through 43.43.845.

Requesting Agency \_\_\_\_\_

Applicant's Signature \_\_\_\_\_

Applicant's Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_



# Certificate of Immunization Status (CIS)

DOH 348-013 January 2015

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 Information System.

**Child's Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Birthdate (mm/dd/yyyy):** \_\_\_\_\_ **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.  
 I certify that the information provided on this form is correct and verifiable.

Vaccine	Dose	Date			Parent/Guardian Signature Required	Date
		Month	Day	Year		
<b>◆ Hepatitis B (Hep B)</b>						
	1					
	2					
	3					
or Hep B - 2 dose alternate schedule for teens						
	1					
	2					
<b>■ Rotavirus (RV1, RV5)</b>						
	1					
	2					
	3					
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>						
	1					
	2					
	3					
	4					
	5					
<b>◆ Tetanus, Diphtheria, Pertussis (Tdap)</b>						
	1					
<b>■ Tetanus, Diphtheria (Td)</b>						
	1					
	2					
<b>● Haemophilus influenzae type b (Hib)</b>						
	1					
	2					
	3					
	4					
<b>■ Influenza (flu, most recent)</b>						

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, OR 3 below (see #.5 on back)**  
 1)  Chickenpox disease verified by printout from the Immunization Information System (IIS) Must be marked by printout (not by hand) to be valid.  
 2)  Chickenpox disease verified by healthcare provider (HCP)  
 If you choose this box, mark 2A OR 2B below.  
 2A)  Signed note from HCP attached OR  
 2B)  HCP sign here and print name below:  
 \_\_\_\_\_  
 Licensed healthcare provider signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)  
 Printed Name: \_\_\_\_\_  
 3)  Chickenpox disease verified by school staff from the Immunization Information System

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.**

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	

Licensed healthcare provider signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)  
 Printed Name: \_\_\_\_\_