Information Needed for Registration

Prospective Kindergarten students must be five years old by September 30, 2017. Prospective Pre-Kindergarten students must be four years old by September 30, 2017. All students must have the following documentation to submit a completed registration packet.

• Birth Certificate
• Social Security card
• Up-to-date immunization record
• Completed Registration form
• 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:
  • Original mortgage or original lease agreement/rental contract on company letterhead AND Utility bill (City of Zachary – gas/water bill, showing name and address)
  • Entergy or DEMCO bill or Telephone bill or Tax Assessor’s bill
  • Original, current Medical/Medicare or social security insurance card or Cable TV / Satellite bill
  • Original 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 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.
<table>
<thead>
<tr>
<th><strong>Zachary Community Schools</strong></th>
<th><strong>School Registration</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School</strong></td>
<td><strong>Date</strong></td>
</tr>
<tr>
<td><strong>SID#</strong></td>
<td><strong>Teacher</strong></td>
</tr>
<tr>
<td><strong>Method of Transportation</strong></td>
<td><strong>Bus #</strong></td>
</tr>
</tbody>
</table>

**Student Information**

<table>
<thead>
<tr>
<th>Social Security or ID assigned by previous LA District</th>
<th>Birth Certificate #</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Last Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>First Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Middle Name</strong></td>
<td><strong>Generation</strong> (Jr., III, etc)</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td><strong>Grade</strong></td>
</tr>
<tr>
<td><strong>Primary Ethnic:</strong> (choose one)</td>
<td></td>
</tr>
<tr>
<td>0 White</td>
<td>1 Black</td>
</tr>
<tr>
<td>2 Hispanic</td>
<td>3 Asian</td>
</tr>
<tr>
<td>4 Native American/Alaskan Native</td>
<td>5 Hawaiian/Pacific Islander</td>
</tr>
<tr>
<td><strong>Secondary Ethnic:</strong> (if applicable)</td>
<td></td>
</tr>
<tr>
<td>0 White</td>
<td>1 Black</td>
</tr>
<tr>
<td>2 Hispanic</td>
<td>3 Asian</td>
</tr>
<tr>
<td>4 Native American/Alaskan Native</td>
<td>5 Hawaiian/Pacific Islander</td>
</tr>
</tbody>
</table>

**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**

**Name 1**

**Name 2**

**Name 3**
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

Preferred
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.
Louisiana Student Residency Questionnaire Form
(Form Must Be Included In School Enrollment Packet)

Date ___________  District/Parish ___________________________ School Name ___________________________

Student Name ______________________________________ SSN/ID# _______________________________

Male/Female ___________ Date of Birth ___________ Address _______________________________________

Telephone Number ___________ Last School Attended ___________________________ Current Grade ___________

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 X, Part C, 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. 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 __________________________________________

4. ☐ Yes ☐ No Does your child have a disability or receive any special education services? (Check One)

5. ☐ Yes ☐ No Does your child 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 your child have siblings?
   Name ___________________________ Grade ___________ Name ___________________________ Grade ___________
   Name ___________________________ Grade ___________ Name ___________________________ Grade ___________
   Name ___________________________ Grade ___________ Name ___________________________ Grade ___________

9. The undersigned certifies that the information provided above is accurate.

Print Parent/Guardian Name/Adult Caring for Student Signature Date

(Area Code) Phone number Street Address City State Zip

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 Title Signature (required) Date (Revised 3/2010)
ZACHARY COMMUNITY SCHOOLS

Complete One Per Student

2017 – 2018 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 2017-18 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

Student’s School for 2017-18: _________________________________

Student’s Grade for 2017-18: ______

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
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 School Nursesölink 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.

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Grade</th>
<th>Homeroom Teacher</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Student Name: Last First M.I.</th>
<th>Sex: M ☐ F ☐</th>
<th>DOB:</th>
<th>Grade:</th>
<th>School:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Student’s Mailing Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Student’s Physical Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Mother/Legal Guardian</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
<th>Employer</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Father/Legal Guardian</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
<th>Employer</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of pediatrician/primary care provider</th>
<th>Phone No</th>
<th>Name of medical specialists/clinics</th>
<th>Phone No.</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Cell Phone Number</th>
</tr>
</thead>
</table>

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
IMMUNIZATION REQUIREMENTS FOR PRE-K
(4 years of age or prior to school entry)

Under State Law (Act no. 771) all students are required to have proof of immunization. We must have an up-to-date copy of your child’s immunizations 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

***IMPORTANT***
We are required by the Department of Health and Hospitals to use Louisiana Immunization Network for Kids Statewide (LINKS) web application for recording and reporting all student immunizations. Please note, any immunization given too early or out-of-sequence will be identified as invalid by LINKS and will need to be repeated. If your child’s physician chooses not to repeat the said dose, documentation from the physician is required by the Department of Health and Hospitals to include in our records.

Please contact your child’s school to speak with a school nurse if you have any questions regarding immunizations.

Thank You,
Zachary Community Schools
Nursing Department
# 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

<table>
<thead>
<tr>
<th>Age</th>
<th>Immunizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>HBV</td>
</tr>
<tr>
<td>2 Months</td>
<td>DTaP, Hib, IPV, HBV, PCV&lt;sup&gt;2&lt;/sup&gt;, RV</td>
</tr>
<tr>
<td>4 Months</td>
<td>DTaP, Hib, IPV, PCV, RV</td>
</tr>
<tr>
<td>6 Months</td>
<td>DTaP, Hib, IPV, HBV, PCV, Flu, RV</td>
</tr>
<tr>
<td>12-15 Months</td>
<td>DTaP, Hib, MMR, Var, PCV, HAV</td>
</tr>
<tr>
<td>18-23 Months</td>
<td>HAV</td>
</tr>
<tr>
<td>4 Years of Age</td>
<td>DTaP, IPV, MMR, Var</td>
</tr>
<tr>
<td>Or Prior To</td>
<td></td>
</tr>
<tr>
<td>School Entry</td>
<td></td>
</tr>
<tr>
<td>11-12 Years</td>
<td>Tdap, MCV4, HPV= (VAR, MMR, HBV if needed)</td>
</tr>
<tr>
<td>16 Years</td>
<td>MCV4</td>
</tr>
</tbody>
</table>

### Accelerated Schedule for Children Starting Immunizations Late

#### Children 4 months to 7 years of age

<table>
<thead>
<tr>
<th>Visit</th>
<th>Immunizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>DTaP, Hib*, IPV, MMR, HBV, HAV, Var, Flu, PCV&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>2nd</td>
<td>DTaP, Hib, HBV, IPV, PCV, Flu (4 wks. after the 1st visit)</td>
</tr>
<tr>
<td>3rd</td>
<td>DTaP, Hib, PCV (4 wks. after the 2nd visit)</td>
</tr>
<tr>
<td>4th</td>
<td>DTaP, Hib, HBV, IPV, PCV, HAV (6 mos. after the 2nd visit)</td>
</tr>
</tbody>
</table>

#### Children 7-18 years of age

<table>
<thead>
<tr>
<th>Visit</th>
<th>Immunizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Tdap, IPV, HBV, MMR, Var</td>
</tr>
<tr>
<td>2nd</td>
<td>Tdap, IPV, HBV, MMR</td>
</tr>
<tr>
<td>3rd</td>
<td>Tdap, IPV, HBV</td>
</tr>
<tr>
<td>11-12</td>
<td>Tdap, MCV4, HPV= (Var, MMR, HBV, IPV if needed)</td>
</tr>
<tr>
<td>16</td>
<td>MCV4</td>
</tr>
</tbody>
</table>

### Vaccine Abbreviations


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 visit the National Immunization Program website at [www.cdc.gov/vaccines](http://www.cdc.gov/vaccines) or call the National Immunization Hotline at 1-800-232-2522 (English) or 1-800-232-0233 (Spanish).