SAMENA

• SWIM & RECREATION CLUB •

PRESCHOOL

3-5 Year Old Program

Registration Packet 2017-2018

…where swimming is part of the curriculum.

Samena Swim and Recreation Club
15231 Lake Hills Blvd. Bellevue, WA 98007
Phone: **(425) 746-1160** Fax: **(425) 746-4485**
www.samena.com

Preschool Coordinator: Sherie Igou, ext.140

SAMENA

• SWIM & RECREATION CLUB •

PRESCHOOL

…where swimming is part of the curriculum.

3-5 Year Old Program

Thank you for enrolling in the Samena Preschool 3-5 year old Program. We take pride in offering a quality, well-rounded program that has been teaching children for over 40 years. A unique benefit to our curriculum is a swim lesson with professional swim instructors the last half-hour of each day.

Children must be 3 years old by August 31, 2017 and fully toilet trained to be eligible for enrollment. Ages are mixed, 3 to 5 year olds. The ratio is 1:10 (one teacher for up to 10 students). Our teaching team is experienced, creative and caring. Age-appropriate activities include: art, reading and writing skills development, number recognition, music, science, cooking, storytelling, health & exercise, Kindergarten readiness, and more. Tuition rates are on a monthly basis. Tuition and curriculum is based on a ten month program. Our holiday and vacation schedule follow the Bellevue School District calendar.

Enrollment Options & Fees for School Year 2017/2018:

Morning (AM) Session: 9am – 12pm OR Afternoon (PM) Session: 1pm – 4pm

5, 4, 3, or 2 days a week with the following schedule:

5 days: Monday – Friday	AM only
4 days: Monday – Thursday	PM only
3 days: Mon/Wed/Fri	AM only
2 days: Mon/Wed	PM only
2 days: Tue/Thu	AM or PM

Monthly Tuition rates:

	Member	Program Member
5 days per week:	$550	$735
4 days per week:	$425	$560
3 days per week:	$350	$455
2 days per week:	$285	$360

1. A non-refundable $110 registration fee must accompany the completed Preschool Registration Form and Preschool Program Contract. These 3 items will reserve your spot.
2. September 2017 (first month) and June 2018 (last month) tuitions are due by June 1, 2017.
3. In the event of a waitlist, a $110 waitlist fee is required. If we are unable to secure you a place in the preschool by August 1, 2017, the fee is refundable. If we have a space for your child and you choose not to enroll, the fee is non-refundable.
4. Cancellation policy: Withdraw by June 30, 2017 and the last month tuition will be refunded. As of July 1, 2017, there are no refunds.
5. School forms will need to be completed for all enrolled students prior to attending in Sept.
6. It is recommended that parents complete an Authorization Agreement for Automatic Payment (page 11 **or** 12) to have Tuition automatically deducted each month.

Keep this page for your records. The above information also appears on the Program Contract (copy on reverse), which you will sign & submit at time of Enrollment (page 5)

SAMENA
• SWIM & RECREATION CLUB •

PRESCHOOL

3-5 Year Old Program Contract 2017-2018

PARENT COPY

Original must be signed on Reverse of Registration Form, page 5

Thank you for choosing the Samena Preschool. We look forward to having your child in our program this school year. Please read and sign this form and return with your Preschool Registration Form. The remaining forms may be submitted by August 31, 2017.

Payment Policy:

- **Registration Fee:** A non-refundable $110 registration fee must accompany a Preschool Registration Form and Preschool Program Contract.
- **September 2017** (first month) and **June 2018** (last month) tuitions are due by **June 1, 2017**.
- **Tuition payments** are due by the first of the month.
- **Monthly tuition** is calculated based on the total cost of the school year and then divided equally by 10 months. This allows all monthly payments to be the same regardless of the number of days in the month. There is no change in tuition due to family vacations, time off, etc.
- **Cancellation Policy:** Once paid, the first month's tuition is non-refundable. **Withdraw by June 30, 2017** and the last month's tuition will be refunded. After July 1, 2017, there are no refunds.
- **Withdrawal Policy:** Written notice must be delivered to the Preschool Coordinator at least 30 days before the 1st of the month from which you are withdrawing from the program or changing days. Our preschool program is designed to operate on the school year calendar with a commitment for September through June.

Additional Fees:

- **Waitlist Fee:** In the event of a waitlist, a $110 waitlist fee is required. If we are unable to secure you a place in the Preschool by August 1, 2017, this fee is refundable. If we have a space for your child and you choose not to enroll, the waitlist fee is non-refundable.
- **Schedule Changes:** There is no charge to add days to your current program beyond the difference in tuition, if space is available. <u>There is a $50 administrative change fee to decrease the number of days attending.</u>
- **Late Pick Ups:** Our programs close at Noon and 4pm. A fee is charged at a rate of $10/per each 10 minute increment you are late past Noon and 4pm. The late fee is paid the day of the occurrence at the front desk and is not prorated. Please call if you will be late for any reason.

Additional Information:

- **Medication:** If your child requires medication, the medication information sheet must be completed, available from the lead teacher, authorizing Samena staff to administer medications to your child. Medication must be provided in its original container with written directions and dosing instructions for your child.
- **Communication:** For your child's safety, we ask that you provide in writing any changes to your emergency contacts including address and phone changes. A communication change form is available from the lead teacher.
- **Promotions materials:** We request permission for the Samena Club to use any pictures or video taken of your child in future promotional materials for the Samena Club only. Samena would have exclusive use of the photographs or videos; no photos will be sold. If you wish for your child to not be included in any promotional materials, please indicate this on Promotions Use Permission Form located in this packet and return by August 31, 2017.

My Signature on original indicates that I/we agree to the Terms of the Samena Club Preschool, as listed on this contract. I have read and understand the terms of this agreement. I agree that I and all persons participating in the Samena Club Preschool are bound by and shall comply with the rules and regulations of the Samena Club as they may be amended from time to time.

SAMENA
• SWIM & RECREATION CLUB •

FOR OFFICE USE
Member #: _____
Non Member ID #: _____
Input in Preschool Database: _____

PRESCHOOL
3-5 Year Old Program
2017-2018 REGISTRATION FORM

Program Contract must be signed on the Reverse of this Form at time of Registration
Additional forms need to be completed prior to the school year

□ Member □ Non-Member

Child's Name: _____ □ M □ F

Birth Date: ____/____/____ Age at start of school: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian: _____ Occupation: _____

Parent/Guardian: _____ Occupation: _____

Home Address: _____
Street Address City/Zip

Email Address: _____

Does your child have previous preschool experience? □ Yes □ No

Has your child had previous swim instruction? □ Yes □ No

Please indicate your session choice, AM or PM:

_____ AM session (9am - 12 pm) Please select one:

□ **5** days, Mon – Fri AM □ **3** days, M/W/F AM □ **2** days, Tue/Th AM

_____ PM session (1pm - 4pm) Please pick 2, 3, or 4 days a week:

□ **4** days, Mon – Thur PM □ M/T/W/Th PM (Please circle which days)

Registration information: 425.746.1160 ext. 0; email: sheriei@samena.com

----------For Office Use Only----------

Registration Fee: Date: _____ $ _____ Pay Method*: _____ Received by:_____

First Mo. Tuition: Date: _____ $ _____ Pay Method*: _____ Received by:_____

Last Mo. Tuition: Date: _____ $ _____ Pay Method*: _____ Received by:_____

For Pay Method, please write: 'CC', "Ck #" or 'Cash'

----------Wait List----------

Days desired: AM- □ Mon/Wed/Fri □ Tues/Thur PM- □ Mon/Wed □ Tues/Thur

Wait List Deposit: Date: _____ $ _____ Pay Method*: _____ Received by:_____

SAMENA
• SWIM & RECREATION CLUB •

PRESCHOOL

3-5 Year Old Program Contract 2017-2018

SAMENA COPY

Thank you for choosing the Samena Preschool. We look forward to having your child in our program this school year. Please read and sign this form and return with your Preschool Registration Form. The remaining forms may be submitted by August 31, 2017. A copy for your records is included on page 3.

Payment Policy:

- **Registration Fee:** A non-refundable $110 registration fee must accompany a Preschool Registration Form and Preschool Program Contract.
- **September 2017** (first month) and **June 2018** (last month) tuitions are due by **June 1, 2017**.
- **Tuition payments** are due by the first of the month.
- **Monthly tuition** is calculated based on the total cost of the school year and then divided equally by 10 months. This allows all monthly payments to be the same regardless of the number of days in the month. There is no change in tuition due to family vacations, time off, etc.
- **Cancellation Policy:** Once paid, the first month's tuition is non-refundable. **Withdraw by June 30, 2017** and the last month's tuition will be refunded. After July 1, 2017, there are no refunds.
- **Withdrawal Policy:** Written notice must be delivered to the Preschool Coordinator at least 30 days before the 1st of the month from which you are withdrawing from the program or changing days. Our preschool program is designed to operate on the school year calendar with a commitment for September through June.

Additional Fees:

- **Waitlist Fee:** In the event of a waitlist, a $110 waitlist fee is required. If we are unable to secure you a place in the Preschool by August 1, 2017, this fee is refundable. If we have a space for your child and you choose not to enroll, the waitlist fee is non-refundable.
- **Schedule Changes:** There is no charge to add days to your current program beyond the difference in tuition, if space is available. <u>There is a $50 administrative change fee to decrease the number of days attending.</u>
- **Late Pick Ups:** Our programs close at Noon and 4pm. A fee is charged at a rate of $10/per each 10 minute increment you are late past Noon and 4pm. The late fee is paid the day of the occurrence at the front desk and is not prorated. Please call if you will be late for any reason.

Additional Information:

- **Medication:** If your child requires medication, the medication information sheet must be completed, available from the lead teacher, authorizing Samena staff to administer medications to your child. Medication must be provided in its original container with written directions and dosing instructions for your child.
- **Communication:** For your child's safety, we ask that you provide in writing any changes to your emergency contacts including address and phone changes. A communication change form is available from the lead teacher.
- **Promotions materials:** We request permission for the Samena Club to use any pictures or video taken of your child in future promotional materials for the Samena Club only. Samena would have exclusive use of the photographs or videos; no photos will be sold. If you wish for your child to not be included in any promotional materials, please indicate this on Promotions Use Permission Form located in this packet and return by August 31, 2017.

My Signature below indicates that I/we agree to the Terms of the Samena Club Preschool, as listed on this contract. I have read and understand the terms of this agreement. I agree that I and all persons participating in the Samena Club Preschool are bound by and shall comply with the rules and regulations of the Samena Club as they may be amended from time to time.

Parent/Guardian Name: _____ Child's Name: _____

Signature: _____ Date: _____

SAMENA
• SWIM & RECREATION CLUB •

PRESCHOOL
2017-18 MEDICAL & CONTACT INFORMATION

Please print and complete all details.

Participant's Name: _____

Date of Birth: _____/_____/_____ **Gender**: □ **Male** □ **Female**

Parent/Guardian's Name: _____

Address: _____

City: _____ **Zip:** _____

Home Phone: (____) _____ **Day Phone**: (____) _____

Cell Phone: (____) _____ **Email Address:** _____

Participant's Medical Information:

1. Physician's Name: _____ Phone :(____) _____
2. Date of last physical/Doctor appointment: _____
3. Is your child currently taking any medications? □ No □ Yes If *Yes*, please describe:

   _____

   Dosage: _____
4. Does your child have any allergies? □ No □ Yes If *Yes*, please describe:

   _____
5. Hospital Preference: _____
6. Is there other information (or special needs) which the teaching staff should be aware of?

   _____

   _____
7. Brothers/sisters & ages? _____

Emergency Contact Information

In case of an emergency, the Samena Staff is directed to call 911 immediately, then the parent or guardian. If you cannot be reached, please list two people most likely to be home and able to assist your child.

Name: _____ **Relation**: _____
Phone: (day) _____ Phone: (other) _____
Name: _____ **Relation**: _____
Phone: (day) _____ Phone: (other) _____

Authorized People Allowed to Pick up My Child:

Name: _____ **Relation**: _____
Phone: (day) _____ Phone: (other) _____
Name: _____ **Relation**: _____
Phone: (day) _____ Phone: (other) _____
Name: _____ **Relation**: _____
Phone: (day) _____ Phone: (other) _____

SAMENA
• SWIM & RECREATION CLUB •

PRESCHOOL

Consent to Medical Care & Treatment of Minor Children

I, _____ (parent/legal guardian), hereby give

permission that my child, _____, may be given emergency treatment to include first aid and CPR by a qualified staff member at Samena Club. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health in case I cannot be contacted. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

_____ _____
Signature of Parent/Guardian Date

Promotions Use Permission

Samena Club requests your permission to use your son or daughter's photograph in Samena promotions materials. Periodically we take pictures and videos for commercial use of the children during their preschool activities. We use these for our brochures and other Samena Club advertising. Samena has exclusive use of the photographs or videos.

_____ Yes, this is acceptable.

_____ No, this is not acceptable.

_____ _____
Signature of Parent/Guardian Date

Certificate of Immunization Status (CIS)

DOH 348-013 January 2015

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

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

Parent/Guardian Signature Required **Date**

Symbols below: ◆ Required for School and Child Care/Preschool
● Required for Child Care/Preschool Only
■ Recommended, but not required

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

Parent/Guardian Signature Required **Date**

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

Vaccine	Dose	Date		
		Month	Day	Year
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			
	5			
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox)				
	1			
	2			
■ Hepatitis A (Hep A)				
	1			
	2			
■ Human Papillomavirus (HPV) – does not print from the IIS; write dates in by hand				
	1			
	2			
	3			
■ Meningococcal (MCV, MPSV)				
	1			
	2			

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 (MD, DO, ND, PA, ARNP) **Date**

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.

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

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) **Date**

Printed Name:

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

#1 To print with information filled in: First, ask if your healthcare provider's office puts vaccination history into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS**, and return it to school or child care. If your provider's office does not use the IIS, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

Vaccine	Dose	Date		
		Month	Day	Year
◆ **Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)**				
DTaP	**1**	01	12	2011
DTaP	**2**	03	20	2011
DTaP	**3**	06	01	2011

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#5 If your child had chickenpox (varicella) disease and not the vaccine, **use only one** of these three options to record this on the CIS:

1) ❑ If your child's CIS is printed directly from the IIS (by your healthcare provider or school), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the IIS printout (not by hand).

2) ❑ If your healthcare provider can verify that your child had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your provider, or 2B if your provider signs and dates in the space provided. Be sure your provider's full name is also printed.

3) ❑ If school staff access the IIS and see verification that your child had chickenpox, they will mark box 3.

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your healthcare provider fill in this box. Ask your provider to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS**, and return to the school or child care.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	FluLaval	Flu	Ipol	IPV	PedvaxHIB	Hib	Twinrix (Twnrx)	Hep A + Hep B
Adacel	Tdap	FluMist	Flu	Infanrix	DTaP	Pentacel (Pntcl)	DTaP + Hib + IPV	Vaqta	Hep A
Afluria	Flu	Fluvirin	Flu	Kinrix (Knrx)	DTaP + IPV	Pneumovax	PPSV or PPV23	Varivax	Varicella
Boostrix	Tdap	Fluzone	Flu	Menactra	MCV or MCV4	Prevnar	PCV or PCV7 or PCV13		
Cervarix	HPV2	Gardasil	HPV4	MenHibrix (Mnhbrx)	Meningococcal C/Y-HIB-PRP	ProQuad (PrQd)	MMR + Varicella		
Daptacel	DTaP	Havrix	Hep A	Menomune	MPSV or MPSV4	Recombivax HB	Hep B		
Engerix-B	Hep B	Hiberix	Hib	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)		
Fluarix	Flu	HibTITER	Hib	Pediarix (Pdrx)	DTaP + Hep B + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	*Haemophilus influenzae* type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (IIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

DOH 348-013 January 2015

Washington State Department of Health

DOH 348-106 Jan 2015

Certificate of Exemption

SIDE A:
For Religious, Personal, Philosophical, and Medical Exemptions[1]

FOR OFFICE USE ONLY CHILD'S LAST NAME _____ FIRST NAME _____ M.I. _____

PART 1: PARENT OR GUARDIAN INSTRUCTIONS

In order for this form to be valid for religious, personal, philosophical, or medical reasons, please:

- **Step 1:** Fill in your child's information in Boxes 1-4
- **Step 2:** Read the Parent/Guardian Declaration
- **Step 3:** Provide your initials where indicated
- **Step 4:** Print your name, sign, and date in Boxes 5-6
- **Step 5: Have a provider complete Part 2 of this form**

1. Child's Last Name

2. Child's First Name and Middle Initial

3. Birthdate (mm/dd/yyyy) _____/_____/_____

4. Gender
☐ Male
☐ Female

I am the parent or legal guardian of the above named child. One or more required vaccines are in conflict with my personal, philosophical, or religious beliefs.

Parent/Guardian Declaration

I understand that:

- *My child may not be allowed to attend school or child care during an outbreak of the disease that my child has not been fully vaccinated against.* _____ ***(initial)***
- *Exempting my child from any or all required vaccine(s) may result in serious illness, disability, or death to my child or others. I understand the risks and possible outcomes of my decision to exempt my child.* _____ ***(initial)***
- *The information provided on this form is complete and correct.* _____ ***(initial)***

5. Print Parent/Guardian Name

6. Parent/Guardian Signature and Date _____/_____/_____

PART 2: HEALTHCARE PROVIDER INSTRUCTIONS

In order for this form to be valid, please:

- **Step 1:** Mark which disease(s) and what type of exemption is requested. If medical write a **T** for Temporary or **P** for Permanent.
- **Step 2:** Discuss the benefits and risks of immunizations with the parent or guardian
- **Step 3:** Read the Provider Declaration
- **Step 4:** Print your name, credentials, sign, and date in Boxes 7-8

Vaccine	Personal/ Philosophical	Religious	Medical (T/P)**	Expiration Date for Temporary Medical
Diphtheria				
Hepatitis B				
Hib				
Measles				
Mumps				
Pertussis				
Pneumococcal				
Polio				
Rubella				
Tetanus				
Varicella				
All				

***A provider may grant a medical exemption only if there is a medical contraindication to a vaccine.*

Provider Declaration

I declare that:

- *I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child.*
- *I am a qualified MD, ND, DO, ARNP or PA licensed under Title 18 RCW.*
- *The information provided on this form is complete and correct.*

7. Print Provider Name and Credential **(MD, ND, DO, ARNP, PA)**

8. Provider Signature and Date _____/_____/_____

[1]RCW 28A.210.080-090 "Before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the State Board of Health, or (3) a certificate of exemption signed by a parent or guardian and is either A) signed by a licensed healthcare provider or B) demonstrates membership in a church or religious body that precludes healthcare practitioners from providing medical treatment to children."

Washington State Department of Health

Certificate of Exemption

SIDE B:
For Religious Membership Exemption ONLY

FOR OFFICE USE ONLY CHILD'S LAST NAME _____ FIRST NAME _____ M.I. _____

NOTICE: Complete this side if you belong to a church or religion that objects to the use of medical treatment.[1]

If you have a religious objection to vaccinations, but the beliefs or teachings of your church or religion allow for your child to be treated by medical professionals such as doctors and nurses, then you must use Side A of this Certificate of Exemption.

PARENT OR GUARDIAN INSTRUCTIONS

In order for this form to be legally valid for religious membership reasons, please:

Step 1: Fill in your child's information in Boxes 1-4
Step 2: Read the Parent/Guardian Declaration and provide your initials where indicated
Step 3: Provide the name of the church or religion of which you are a member, and print your name, sign, and date in Boxes 5-7

1. Child's Last Name

2. Child's First Name and Middle Initial

3. Birthdate (mm/dd/yyyy) _____/_____/_____

4. Gender ☐ M ☐ F

I am the parent or legal guardian of the above named child and I am exempting my child from all required vaccinations.

Parent/Guardian Declaration

I understand that:

- *My child may not be allowed to attend school or child care during an outbreak of the disease that my child has not been fully vaccinated against.* _____ ***(initial)***
- *Exempting my child from all required vaccines may result in serious illness, disability, or death to my child or others. I understand the risks and possible outcomes of my decision to exempt my child.* _____ ***(initial)***
- *The information provided on this form is complete and correct.* _____ ***(initial)***

I affirm that I am a member of a church or religion whose teachings preclude healthcare practitioners from providing any medical treatment to my child.

5. Name of Church or Religion of Which You Are a Member

6. Print Parent/Guardian Name

7. Parent/Guardian Signature and Date _____/_____/_____

[1]RCW 28A.210.090 "The parent of legal guardian demonstrates membership in a religious body or a church in which the religious beliefs or teachings of the church preclude a health care practitioner from providing medical treatment to the child."

AUTHORIZATION AGREEMENT FOR
CREDIT or DEBIT CARD (EFT) AUTOMATIC PAYMENTS

For Automatic Payment from Bank Account (ACH), please fill out reverse side instead

Company: **SAMENA CLUB**

I (we) hereby authorize Samena Club or its authorized credit/debit card transaction agent(s) to bill my credit/debit card account indicated below for monthly payment.

Credit/Debit Card type: (Please circle one) Visa Mastercard Discover AmEx

- Last 4 digits of credit card # ___ ___ ___ ___
- Expiration Date: ___ ___ /___ ___
- CVV# (3 or 4 digits): ___ ___ ___ ___
- Name on Card: _____
- Street Address credit card statement is sent to: _____
- Zip Code: _____

This authority is to remain in full force and effect until Samena Club has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Samena Club and the DEPOSITORY a reasonable opportunity to act on it. If I change the account number or financial institution specified, I will provide written authorization for the change to Samena Club.

Membership Number: _____

Primary Member Name: (Please Print) _____

Primary Member Signature: _____Date Signed:_____

Spouse: (if applicable)

Spouse Name: (Please Print or Type) _____

Spouse Signature: _____Date Signed: _____

15231 Lake Hills Blvd. Bellevue WA 98007
(425) 746-1160 Attn: Sharon McClain (Ext. 114) Fax: (425) 746-4485

AUTHORIZATION AGREEMENT FOR
ACH (Bank Account) AUTOMATIC PAYMENTS

For Automatic Payment from Credit/Debit Card (EFT), please fill out reverse side instead

Company: SAMENA CLUB **Type of Account: □ Checking □Savings**

I (we) hereby authorize Samena Club to initiate an electronic debit to my (our) account identified below and its depository (bank), to debit the same to said account.

Depository Name: _____Branch _____

City, State, Zip:

_____

Transit/Routing No. □:__ __ __ __ __ __ __ __ __ □: Account No. __

(first 9 numbers on bottom left of check)

I have read and agree to the terms of this application. This authorization is to remain in full force and effect until Samena Club and its DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford Samena Club and its DEPOSITORY a reasonable opportunity to act on it.

I further understand that it is my sole responsibility to maintain sufficient available funds in my account to provide for payment to Samena Club on the due date. In the vent that there are insufficient funds in the account and my financial institution denies payment to Samena Club, I understand that Samena Club will add a $10.00 service fee to my account.

Membership Number: _____

Primary Member Name: (Please Print or Type)

_____

Primary Member Signature: _____Date Signed: _____

Spouse: (if applicable)

Spouse Name: (Please Print or Type)

_____

Spouse Signature: _____Date Signed: _____

(ATTACH VOIDED CHECK)

15231 Lake Hills Blvd. Bellevue WA 98007 (425) 746-1160
Attn: Sharon McClain (Ext. 114) Fax: (425) 746-4485