



**CHINESE AMERICAN  
INTERNATIONAL  
华美国际 SCHOOL**

**2022/23  
Enroll Application**

**PRESCHOOL & KINDERGARTEN**

STUDENT INFORMATION				REGISTRATION							
Student Last Name		Student First Name			Time	M - F	M/W/F	Tu/Th*			
Age as of Sept 1, 2022		Birth Date		Desired Start Date		Preschool- AM (3 or 4)	9:00am - 12:45pm	\$7,580	\$5,330	\$4,090	
Gender		Country of Citizenship				Preschool- FULL (3 or 4)	9:00am - 3:30 pm	\$10,980	\$7,680	\$5,600	
Will student attend another school?		School Name?				Kindergarten - FULL (5)	9:00am - 3:30 pm	\$10,980	NA	NA	
<b>Notes:</b> Students enrolling M-F are given first priority. Admission to CAIS is on a first-come, first-served basis. <b>Before and After Care registration forms will be included in your acceptance packet.</b>											
PARENT / GUARDIAN 1				PARENT / GUARDIAN 2							
Last Name		First Name		Last Name			First Name				
Address				Address							
City	ST	Zip		City	ST	Zip					
Home Phone		Cell Phone		Home Phone		Cell Phone					
Email Address				Email Address							
Employer / Occupation				Employer / Occupation							
NON-DISCRIMINATION POLICY											
CAIS admits students of any religion, race, color, national or ethnic origin to all the rights, privileges, programs and activities generally accorded or made available to students at the school. It does not discriminate in the administration of its education policies, admission policies, or other school administered programs.											
REENROLLMENT FEE AND PAYMENT INFORMATION											
I/we wish to enroll my/our child in the Chinese American International School (CAIS). I/we have enclosed a non-refundable reenrollment fee of \$300. It is understood the reenrollment fee will be credited toward tuition charges and will not be refunded if student chooses to not enroll.											
I/we select the following option for payment of the tuition amount circled above. Once our child is accepted, I/we understand the payment amounts will be clearly defined in a tuition payment schedule.											
_____ Option A - 3% discount when 1/3rd is paid on or before 8/1/2022 & 2/3rds paid on or after 1/1/2023											
_____ Option B - 10 equal payments due on the 1st of each month starting August 1, 2022 to include a prorated annual \$50 billing fee											
Signature of Parent / Guardian 1				Date		Signature of Parent / Guardian 1				Date	
_____				_____		_____				_____	
OFFICE USE ONLY											
Application Date	App. Fee Recv'd	Accepted into Grade	Waitlist for Grade	Declined	Initials						
_____	_____	_____	_____	_____	_____						

**\$300 Non-Refundable Re-enrollment Deposit is due with the reenrollment form. Please return on or before May 15, 2022**

CAIS, LLC  
85 Laurel Street  
Lake Oswego OR 97034  
408-614-6285

MEDICAL/DENTAL INFORMATION AND AUTHORIZATION	
Primary Care Physician	Phone
Medical Insurance Provider	Policy Number
Dentist	Phone
My child may be given non-prescribed medication as indicated on the container. This may include sunscreen, children's pain reliever and antibacterial first aid cream. Syrup of ipecac may be administered if deemed necessary by the poison control operator. The child's parent or guardian will be contacted prior to administering non-prescription pain relievers. Prescription medications must be current and a permission slip is required per each medication.	YES NO
In an emergency, CAIS has my permission to call an ambulance, or take my child to any available physician or hospital at my expense to obtain medical treatment. In most emergencies, 911 will be called and the child is transported to the nearest hospital and treated by the on-call physician. The parent or guardian of the child is notified as soon as possible.	YES NO
Does your child have allergies?	YES NO
List all allergies or other health problems, including instructions for providing best possible care in regard to stated conditions. Do any of the medical conditions restrict the child's activities?	

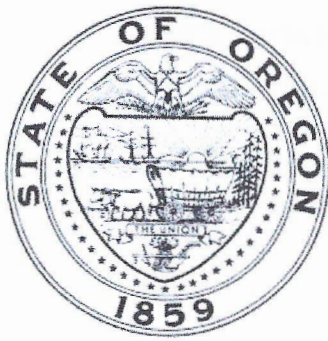
EMERGENCY CONTACT INFORMATION	
In an emergency, parents will be notified first. Contacts below will be called when parents are unavailable.	
Name (first, last)	Home Phone
Relationship	Cell Phone
Name (first, last)	Home Phone
Relationship	Cell Phone
PICK UP AUTHORIZATION	
Please provide information for people other than parents who are authorized to pick up your child.	
Name (first, last)	Cell Phone
Relationship	License Number
Name (first, last)	Cell Phone
Relationship	License Number

PERMISSION TO PHOTOGRAPH	
I authorize the Chinese American International School to use my child's photograph without name or any other personal identifiers in marketing materials and media promoting the Chinese American International School.	YES or NO

Signature of Parent or Guardian

Date

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# Oregon Certificate of Immunization Status

## Oregon Health Authority, Immunization Program

Oregon law requires proof of immunization be provided or an exemption be signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Health Authority, Immunization Program and may be released to the Authority or the local public health department by the school or children's facility upon request of the Authority. Please list immunizations in the order they were received.

Child's Last Name <i>Apellido</i>	First <i>Primer Nombre</i>	Middle Initial <i>Segundo Nombre</i>	Birthdate <i>Fecha de Nacimiento</i>
Mailing Address <i>Dirección</i>	City <i>Ciudad</i>	State <i>Estado</i>	Zip Code <i>Código Postal</i>
Parents' or Guardians' Names <i>Nombre de los padres o guardian</i>		Home Telephone Number <i>Número de Teléfono</i>	

Complete for all  
 Up-to-date  
 Medical  
 Non medical

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria/Tetanus/Pertussis (DTaP, Tdap, Td)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)
Booster Dose Tdap					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] <input type="checkbox"/> Check here if child has had chickenpox disease _____ (mm/dd/yy)					
Measles/Mumps/Rubella (MMR)					
<i>or</i>					
Measles vaccine only					
Mumps vaccine only					
Rubella vaccine only					
Hepatitis B (Hep B)					
Hepatitis A (Hep A)					
Haemophilus Influenzae Type B (Hib) (Only children less than 5 years)					

**I certify that the above information is an accurate record of this child's immunization history.**

Signature\* \_\_\_\_\_ Date \_\_\_\_\_

Update Signature \_\_\_\_\_ Date \_\_\_\_\_

Update Signature \_\_\_\_\_ Date \_\_\_\_\_

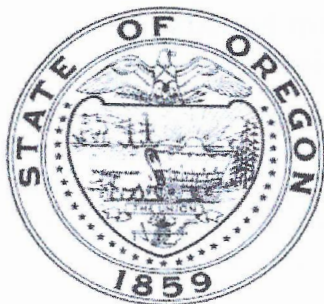
Update Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>For school/facility use only</b>
School/facility Name
Student ID Number
Grade

\*Parent, guardian, student at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

**Continued On Reverse Side**





# Oregon Certificate of Immunization Status, Page 2

## Oregon Health Authority, Immunization Program

Child's Last Name <i>Apellido</i>	First <i>Primer Nombre</i>	Middle Initial <i>Segundo Nombre</i>	Birthdate <i>Fecha de Nacimiento</i>
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Recommended Vaccines	Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
	Pneumococcal (PCV) (Only in children less than 5 years)					
	Meningococcal (MCV4, MPSV4)					
	Human Papilloma Virus (HPV) (9 years or older)					
	Influenza (Flu)					
	Other Vaccine Please specify:					
	Other Vaccine Please specify:					

### For medical exemptions:

**Please submit a letter signed by a licensed physician stating:**

- Child's name
- Birth date
- Medical condition that contraindicates vaccine
- List of vaccines contraindicated
- Approximate time until condition resolves, if applicable
- Physician's signature and date
- Physician's contact information, including phone number

**For Immunity Documentation** (history of disease or positive titer): **Please submit a letter signed by a licensed physician stating:**

- Child's name and birth date
- Diagnosis or lab report
- Physician's signature and date

### Nonmedical Exemption:

I have received information regarding the benefits and risks of immunizations. I understand that my child may be excluded from school or child care attendance if there is a case of disease that could be prevented by vaccine. I have attached the required document from (check one):

- ☐ A health care practitioner  
☐ The vaccine educational module approved by the Oregon Health Authority

I understand that I may decline one or more vaccinations for my child and request that my child be exempted from the following required immunizations (check all that apply):

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Diphtheria/ Tetanus/Pertussis | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Polio                         | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Varicella                     | <input type="checkbox"/> Hib         |
| <input type="checkbox"/> Measles/Mumps/Rubella         |                                      |

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

### Optional:

ORS 433.267 states that this document may include the reason for declining the immunization. Immunization is being declined because of:

- ☐ Religious belief    ☐ Philosophical belief    ☐ Other

I certify that the above information is an accurate record of this child's immunization history and exemption status.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Update Signature \_\_\_\_\_

Date \_\_\_\_\_

Update Signature \_\_\_\_\_

Date \_\_\_\_\_

Update Signature \_\_\_\_\_

Date \_\_\_\_\_