WASATCH ACADEMY

2023-24 New Student Required Enrollment Forms Checklist

Welcome to Wasatch Academy! We are excited to welcome students to Wasatch Academy on Sunday, August 27!! *Registration will begin at 12 pm, with dorms opening after 12 pm for students to begin moving their things in, unpacking, etc.*

Please complete and return the enrollment forms to admissions@wasatchacademy.org or fax them back to admissions at 435.462.1450 **by August 15.**

Medical Paperwork

- ☐ Medical Release Form
- ☐ Release for Medical Treatment Form
- ☐ Prescription Management and Pharmacy Acknowledgment
- ☐ School Immunization Record
- ☐ Participant & Parental Disclosure and Consent
- ☐ Pre-participation Physical Evaluation *(completed by a doctor after August 31, 2022)*
- ☐ Pre-participation Medical History *(completed by parents/guardian & student)*
  - An annual physical is required of all students.
  - Physicals completed by a doctor after August 31st, 2022, are acceptable.
- ☐ Copy of Medical Insurance Card *(front and back)*
  - Medical insurance is required for all boarding students.
  - Please submit current health insurance information, with a United States billing address, before your student's arrival.
  - Wasatch Academy Wellness Center can be reached by phone at 435.462.1419, 801.931.2134 fax, or by email at *wellnesscenter@wasatchacademy.org.*

Academics & Requesting Courses for Fall 2023-24

- ☐ Official/Current Transcript (submit most recent transcript)
- ☐ Request Fall Courses Use this link to request courses for New Students
  - AnneMarie Lund is the WA Registrar and can be reached at 435.462.1425 office, 435.462.1450 fax, or email *annemarie.lund@wasatchacademy.org.*

WASATCH ACADEMY

2023-24 New Student Required Enrollment Forms Checklist, continued

Travel Details

- [ ] Travel Forms
    - Flights should arrive at the Salt Lake City International Airport prior to 8 pm if possible and depart prior to 2 pm if possible.
    - *For planning purposes, please complete & return the travel form to us, whether your student is flying alone or you are accompanying your student to campus.*
    - Abbi Kennedy is the WA Student Transportation Coordinator and can be reached at travel@wasatchacademy.org and by cell at 801.592.8062.

Please let us know if you have any questions regarding the enrollment process. We look forward to your student joining us soon!!

Warm regards,

Michelle Huntsman
Admissions Associate
Wasatch Academy
Admissions Department
435.462.1410 / 435.462.1450 Fax

WASATCH ACADEMY

Medical Release Form

This release is effective for the duration of student's enrollment at Wasatch Academy
Please print clearly

Student Information:

Student Name: ____ Male/Female
First Middle Last

Birth Date (m/d/year) ____________________SS#____________________Grade____________

Home Address: ____
Street and PO Box (if applicable)

____
City State/District Country Zip Code

Primary Parent______________________________ Home Phone:______________________________

Business Phone#______________________________ Cell Phone #______________________________

Email Address:______________________________ Fax#______________________________

Additional Parent______________________________ Home Phone#______________________________

Business Phone#______________________________ Cell Phone #______________________________

Email Address:______________________________ Fax#______________________________

Person to contact regarding student's health: ______________________________

Phone number ______________________________

Student Medical Treatment Information: Current Physician ______________________________

Current Medications, Dosages, Times Given: ______________________________

Number of each pill student should have upon arrival at Wasatch Academy? ______________________________

Wasatch Academy cannot be responsible for any medications you send with your child.

Allergies or Chronic Illness: ______________________________ Date of last Tetanus shot____________

ALL INTERNATIONAL STUDENTS MUST ARRIVE AT WASATCH ACADEMY WITH PROOF OF TUBERCULOSIS TEST THREE WEEKS PRIOR TO ARRIVAL.

Medical Release: Please sign on the line following your choice.

I authorize Wasatch Academy to administer my student's authorized prescription medications. *If yes, please also complete the **Prescription Management and Pharmacy Acknowledgement** form.*

Yes________________ No____________________

I authorize Wasatch Academy to administer over-the-counter medication to my child as needed.

Yes________________ No____________________

Name of person completing form: ______________________________ Date__________________

Insurance Information – Health Insurance is required for all students prior to their arrival on campus. Please include a legible copy of insurance card, front & back.

Health Insurance Company:____
Address:____
ID #______________________________Group #______________________________
BIN # (usually 5 numbers) ______________________________Processor Control Number (PCN)______________
Full Name of Insured:____
Relationship:______________________________SSN______________________________
Insurance Holder's Date of Birth:____

WASATCH ACADEMY

Release for Medical Treatment

As a parent or legal guardian of ____, a minor born on_____________________________ , I hereby authorize WASATCH ACADEMY to obtain any medical care deemed necessary at my expense. This includes calling an ambulance, taking my child to a physician of school's choice, giving consent for any x-ray, examination diagnosis, administration of anesthesia, medical of surgical treatment, and/or hospitalization. If I, or person(s) listed below, cannot be reached by telephone, I authorize WASATCH ACADEMY to obtain any emergency medical care deemed necessary at my expense.

I, the undersigned, understand that I will be the primary contact for medical concerns.

Signature: _____________________________________ **Date:** _______________________

Personal Information Release

As a parent or legal guardian of____ , I give WASATCH ACADEMY and its representatives permission to release to house parent, teachers, counselors, physicians, psychiatrists, and any other persons assisting with my child's care and well being any pertinent medical, psychological or psychosocial information regarding my daughter/son as necessary.

Signature: _______________________________________ **Date:** ___________________

Emergency Information

In the event of an accident or other emergency, if the school cannot reach the parent or legal guardian, please give the information requested below for persons authorized to grant permission for medical treatment of your child.

Name: _____________________________________ **Relationship:** ____________________________

Home Phone: _____________________________ **Business/Cell Phone:** ___________________

Name: _____________________________________ **Relationship:** ____________________________

Home Phone: _____________________________ **Business/Cell Phone:** ___________________

*****If any of the listed information changes at any time, PLEASE notify the Wellness Center at 1.435.462.1419 IMMEDIATELY.**

Please contact **Terrel's Pharmacy** with your insurance information and a credit card number for any co-pays.

Terrel's Pharmacy
1050 S. State Street, Utah 84647
Phone: 435.462.6300 / Fax: 435.462.6301

WASATCH ACADEMY

RE: Prescriptions, Medications, Vitamins, and Supplements

Dear Wasatch Academy Families,

The Wellness Center is excited to care for and ensure the health and well-being of your student while enabling them to learn and grow at Wasatch Academy.

Please know that students are not permitted to have medications, including vitamins, supplements, prescription medications, or over-the-counter medications, in their possession or dorm rooms. While attending Wasatch Academy, these medications will be distributed through the Wellness Center. In order to provide the best care, we ask that you follow these simple guidelines pertaining to medications and supplements:

- Please do not send over-the-counter (OTC) medications with your student to school for occasional use. The Wellness Center has most of these medications in stock at all times. However, if there is a particular OTC medication your student needs to take regularly, it is the parent's responsibility to provide the medication to the Wellness Center. We will then distribute OTC medications as needed.

- Please do not send supplements, oils, vitamins, enzymes, proteins, etc., with your student to school unless your child will be taking them on a daily basis. Should your student need a supplement, please consider a multi-vitamin/mineral combination that can be easily purchased and is approved for distribution in the United States. It is the parent's responsibility to purchase and supply the daily supplement or vitamin, and we encourage you to send a four-month minimum supply.

- If your student requires prescription medication, they must be stabilized on the current prescription medication regimen prior to arrival on campus. To support the ongoing administration of their medication, we ask that the prescription medication has the maximum number of refills permitted by their doctor, if possible, and arrive at campus with at least a full month's supply. All prescriptions are filled at a local pharmacy in Mt. Pleasant, Utah. If your student will need refills of their prescription, please contact the pharmacy with your health insurance information and credit card for them to keep on file for refills. Below is the pharmacy's information.

Terrel's Pharmacy
1050 S. State Street, Utah 84647
Phone: 435.462.6300 / Fax: 435.462.6301

Once again, medication costs and refills are the parents' responsibility. Should your student need a new prescription or a medication refill, the Wellness Center may purchase the prescription with the payment card on file at the pharmacy (preferred method). Or the student may pay for the medication with their own debit/credit card. If you have any questions or concerns regarding these guidelines, please don't hesitate to email or call the Wellness Center at 435.462.1419. We are willing to work through any issues and concerns. We look forward to aiding in your student's health.

Best regards,

Wasatch Academy Wellness Center
wellnesscenter@wasatchacademy.org
Phone: 435.462.1419, Fax: 801.931.2134

WASATCH ACADEMY

Prescription Management and Pharmacy Acknowledgement

If your student is on a current regimen of prescription medications, there are a couple of different options for how we can manage refills. If you have a primary care physician that is managing and prescribing your student's medication, they may or may not be able to send prescriptions out-of-state, depending on their licensure. If your student needs a new prescribing doctor, we can make an appointment at the local family clinic practice for refills. The doctors there are great at prescribing refills for students; however, if any changes need to be made, they prefer the student's primary care physician to make those adjustments.

Please read through the following and select the best option for you and your student:

☐ Your student's medication will be filled at your pharmacy at home, and you will be mailing the refilled medications to Attn: Wellness Center at Wasatch Academy, 120 S. 100 W. Mt. Pleasant, UT, 84647.

☐ Your student will be arriving on campus with enough medication until they go home for the breaks. Refills are not necessary.

☐ Your student's primary care physician will be electronically sending prescriptions to be filled locally at Terrel's Pharmacy.

☐ Your student will need a doctor's visit scheduled at the local clinic, and prescriptions will be filled locally at Terrel's Pharmacy.

If you have opted to have prescriptions filled locally at Terrel's Pharmacy, please be aware that the easiest and most streamlined way to fill prescriptions is to keep a payment card on file at the pharmacy so prescriptions can be paid for as needed. If you are not comfortable doing so, you may need to call and pay over the phone for each monthly refill. Please give them a call at 435.462.6300 to set up their profile, and let them know your student will be attending Wasatch Academy.

Because the pharmacy is located inside the grocery store, charges will come up as "Terrel's Marketplace" in your bank account. Please do not cancel the payment if you see it come up as this instead of a "pharmacy." If you have any questions or concerns, feel free to let us know so we can figure it out prior to canceling the transaction.

Please sign below acknowledging this and agreeing to keep an up-to-date, valid payment card on file at Terrel's Pharmacy.

____

Parent/Guardian Signature *Date*

PRE-PARTICIPATION EXAMINATION FORM

Instructions for completing pre-participation (athletic)
Health Examination and Consent Form

COMPLETING THIS FORM:

1. PLEASE TYPE OR PRINT LEGIBLY
2. Parent/Guardian along with the student are to complete the Health History on page 3 and the Disclosure and Consent Document on page 2. Please note student and parent are to sign both forms. The Health History is to be taken to the physical examination for the physician/provider to review.
3. Physician/Provider is to complete and sign the Physical Examination form on page 4.
4. Entire completed form is to be returned to school administration.

SUBMITTING THIS FORM:

1. School personnel should review form to assure it is completed properly.
2. ORIGINAL copy is to be retained in school files.

QUALIFICATION OF PROVIDERS:

A health examination must be performed annually and the Pre-participation Physical Evaluation Form must be completed before any student may participate in athletic activities sponsored by this Association. A Pre-participation Physical Evaluation Form along with the Disclosure and Consent Document must be on file at the school before any participation in athletic activities.

The health examination must be completed and the form signed by any Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PAC), or Registered Nurse Practitioner (RNP), Doctor of Chiropractics (DC), functioning within the legal scope of their practice.

As part of our quality assurance efforts in best practices and maintenance of credentialing, and acknowledging the need to allow time for certification efforts, the BOT approved that all medical personnel that perform the pre-participation physical exam for student athletes will be required to be "Board Certified"* by their respective disciplines by March 10, 2025.

In addition to maintaining the continuing medical education (CME) required by each medical discipline for state licensure, the BOT approved that NPs, PAs, DCs, DOs and MDs have successfully completed postgraduate education and Board Certifications. As examples: NPs would successfully complete and maintain FNP-BC or FNP-C certifications; PAs would successfully complete NCCPA certification and maintain PANRE or PANRE-LA certifications; DCs would successfully complete and maintain a postgraduate Diplomate program (i.e. Internal Medicine & Family, Sports Medicine, Orthopedics, Pediatrics, etc.); DOs and MDs would successfully complete a postgraduate residency/fellowship program and maintain board certification in one of the 24 Member Boards of ABMS.

*Note: The American Board of Medical Specialties differentiates medical licensure from board certification.

THE UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION DOES NOT PROVIDE PRINTED COPIES OF THIS FORM. PLEASE MAKE ALL NECESSARY COPIES.

Participant & Parental Disclosure and Consent Document

PLEASE NOTE: It is the responsibility of the parent/guardian to notify the school if there are any unique individual problems that are not listed on the Pre-participation Physical Evaluation Form.

Name of Student ______________________ *School* ______________________

Is the student covered by health/accident insurance? ❑Yes ❑No

Name of health insurance provider ______________________

If no insurance provider, explain ______________________

____

____

____

CONSENT FORM

Parent or Guardian Statement of Permission, Approval, and Acknowledgement:

By signing below, I the parent or legal guardian of the above named student do:

- Hereby consent to the above named student participating in the interscholastic athletic program at the school listed above. This consent includes travel to and from athletic contests and practice sessions.
- Further consent to treatment deemed necessary by health care providers designated by school authorities for any illness or injury resulting from his/her athletic participation.
- Recognize that a risk of possible injury is inherent in all sports participation. I further realize that potential injuries may be severe in nature including such conditions as: fractures, brain injuries, paralysis or even death.
- Acknowledge and give consent that a copy of this form will remain in the student's school. I agree that if my student's health changes and would alter this evaluation, I will notify the school as soon as possible but within no longer than 10 days.
- Hereby acknowledge having received education including receiving written information regarding the signs, symptoms, and risks of sport related concussion. I also acknowledge that I have read, understand and agree to abide by the UHSAA Concussion Management Policy and/or the policy of the school listed above. http://www.uhsaa.org/SportsMed/ConcussionManagementPlan.pdf

Parent or Guardian Name ______________________ *Parent or Guardian Signature* ______________________

Date ______________________

Student Statement

By signing below I acknowledge:

- This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Utah High School Activities Association.
- My responsibility to report to my coaches and parent(s)/guardian(s) illness or injury I experience.
- Having received education including receiving written information regarding signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches and parent(s)/guardian(s) any signs or symptoms of a concussion.

Signature of Student ______________________ *Date* ______________________

THIS FORM MUST BE ON FILE AT THE MEMBER HIGH SCHOOL PRIOR TO PARTICIPATION.

ATHLETIC PRE-PARTICIPATION EXAM AND MEDICAL HISTORY

*Must be completed **every school year** by the athlete and parent prior to any try-out, practice, or athletic contest*

NOTE: *If a student athlete is under specific medical management (i.e. medications, etc.) the appropriate medical provider will conduct the pre-participation physical exam as these issues will be appropriately addressed during the exam.*

ATHLETE INFORMATION

Athlete Name: ____ Date of Exam: ________________

Sport(s):____

Birth date: ________________ Age: ______ Grade in school ______ Gender: _____School year: __________

Athlete Cell Phone No. (______)________________ Athlete Address: ________________________________

EXAMINATION: TO BE FILLED OUT BY PHYSICIAN ONLY

Height: __________ Weight: ___________ ▢ Male ▢ Female | Pulse: _______ BP: _____/_____ % Body Fat (opt) _____

Vision: Left_______/_______Right_______/_______ Corrected: ▢ Yes ▢ No Pupils: ▢ Equal ▢ Unequal

Immunizations: Tetanus ___________ MMR _____________ Hep B _____________ Chickenpox____________

GENERAL MEDICAL (please initial)	Normal	Abnormal Findings	MUSCULOSKELETAL (please initial)	Normal	Abnormal Findings
Appearance (Marfan stigmata)			Neck		
Eyes/Ears/Nose/Throat (Pupils Equal, Hearing)			Back		
Lymph Nodes			Shoulder/ Arm		
Heart (murmurs)			Elbow/ Forearm		
Pulses (Simultaneous femoral and radial pulses)			Wrist/ Hand/ Fingers		
Lungs			Hip/ Thigh		
Abdomen			Knee		
Skin (HSV, MRSA, tinea corporis)			Leg/ Ankle		
Neurological			Foot/ Toes		
Genitourinary (males only)			Functional (Duck walk, single leg hop)		

ATHLETIC PARTICIPATION RECOMMENDATIONS *(Physician MUST select one item listed below)*

_______ **FULL & UNLIMITED PARTICIPATION**

_______ **LIMITED PARTICIPATION**—May NOT participate in the following ________________________________

_______ **CLEARED PENDING**—Documented follow up of: ____

_______ **NOT CLEARED FOR ATHLETIC PARTICIPATION**

Physician's Comments: ____

____

____

By signing this form, I acknowledge that I am board certified in a medical specialty, and as such, I am current in my maintenance of credentialing.

Medical Provider: ________________________________
(Please print)
Medical Signature: ______________________ Date: _______

IF THIS FORM IS NOT FULLY COMPLETED INCLUDING DOCTOR ADDRESS AND NUMBER, IT WILL NOT BE ACCEPTED

Physician's Office Address

Telephone: (____) _________________

ATHLETIC PRE-PARTICIPATION EXAM AND MEDICAL HISTORY

*Must be completed **every school year** by the athlete and parent prior to any try-out, practice, or athletic contest*

Athlete Name: ____Date of Birth_________

MEDICAL HISTORY

Medicines: Please list all of the prescription and over-the-counter medicine and supplements (herbal and nutritional) that you are currently taking

____

Allergies: Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy.
☐ Medicines__________________________ ☐ Pollens _________________________ ☐ Food ________________________ ☐ Stinging Insects__________________

ANY "YES" RESPONSES MUST BE EXPLAINED IN FULL AFTER EACH QUESTION IN THE SPACE

GENERAL QUESTIONS	Yes	No		MEDICAL QUESTIONS	Yes	No
Has a doctor ever denied or restricted your participation in sports for any reason?				Do you cough, wheeze or have difficulty breathing during or after exercise?		
Do you have any ongoing medical conditions? If so please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other: ____________________				**Have you ever used an inhaler or taken asthma medication?**		
Have you ever spent the night in the hospital?				Is there anyone in your family who has asthma?		
Have you ever had surgery?				Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No		Do you have groin pain or a painful bulge or hernia in the groin area?		
Have you ever passed out or nearly passed out DURING or AFTER exercise?				Have you had infectious mononucleosis (mono) within the last month?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				Do you have any rashes, pressure sores, or other skin problems?		
Does your heart ever race or skip beats (irregular beats) during exercise?				Have you had a herpes or MRSA skin infection?		
Has a doctor ever told you that you have any heart problems? If so check all that Apply: **☐ High Blood Pressure ☐ High Cholesterol ☐ Kawasaki Disease** **☐ A heart murmur ☐ A heart infection ☐ Other: ____________________**				Do you have a history of seizure disorder?		
Has a doctor ever ordered a test for your heart? (e.g. ECG/EKG, Echocardiogram)?				Have you had any problems with your eyes or vision?		
Do you get light headed or feel more short of breath than expected during exercise?				Have you had any eye injuries?		
Have you ever had an unexplained seizure?				Do you wear glasses or contact lenses?		
Do you get more tired or short of breath more quickly than your friends during exercise?				Do you wear protective eye wear such as goggles, or a face shield?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No		Do you worry about your weight?		
Has any family member or relative died of a heart problem or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?				Are you trying to or has anyone recommended that you gain or lose weight?		
Does anyone in your family have hypertrophic cardiomyopathy, Long QT syndrome, Short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?				Are you on a special diet or do you avoid certain types of foods?		
Does anyone in your family have a heart problem, pacemaker, or implanted Defibrillator?				Have you ever had an eating disorder?		
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?				**HEAT ILLNESS QUESTIONS**	Yes	No
BONE AND JOINT QUESTIONS	Yes	No		**Have you ever become ill while exercising in the heat?**		
Have you ever had an injury to a bone, muscle , ligament or tendon that caused you to miss a practice or a game?				Do you get frequent muscle cramps when exercising?		
Have you ever had any broken, fractured or dislocated bones?				**Do you or someone in your family have sickle cell trait or disease?**		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?				**HEAD AND NECK HEALTH QUESTIONS**	Yes	No
Have you ever had a stress fracture?				Do you have headaches with exercise?		
Have you ever been told that you have or have you had an x-ray for a neck instability or atlantoaxial instability (down syndrome or dwarfism)?				**Have you ever had a head injury or concussion?**		
Do you regularly use a brace, orthotics, or other assistive devices?				**Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problems?**		
Do you have a bone, muscle, or joint injury that bothers you?				Have you ever had numbness , tingling, or weakness in your arms of legs after being hit or falling?		
Do any of your joints become painful, swollen, feel warm or look red?				Have you ever been unable to move your arms or legs after being hit or falling?		
Do you have any history of juvenile arthritis, or connective tissue disease?				FEMALES ONLY		
Have you had any problems with pain, swelling, fracture, sprain, strain, or dislocation in any joint? *Specify below if yes*				When was your first menstrual period (age when started)?		
If yes, check the appropriate box and explain below: ☐ Head ____________________☐ Neck ________________________ ☐ Back ____________________ ☐ Shoulder ______________________ ☐ Arm ____________________ ☐ Elbow ________________________ ☐ Finger ___________________ ☐ Wrist ________________________ ☐Hand ____________________ ☐ Shin/Calf ______________________ ☐Thigh ____________________☐ Knee __________________________ ☐Hip ______________________☐Ankle __________________________ ☐Foot ____				When was your most recent menstrual period? How much time do you usually have from the start of one period to the start of another? How many periods have you had in the last year? What was the longest time between periods in the last year?		

Parent Signature: ______________________________ Date: ____________

UTAH SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent school record (cumulative folder) as defined in Section 53G-9-306 of the Utah Statutory Code and shall transfer with that school record upon request of the student's legally responsible individual. See back for instructions on how to fill out this form.

Student Information

Student Name ______________________________ **Gender** ☐ Male ☐ Female **Date of Birth** ________________

Name of Parent/Guardian ______________________________

USIIS ID ________________ PIN ________________ Student ID Number ________________

Vaccine Information

VACCINE	Record the month, day, & year for each vaccine dose that was given. 1st	2nd	3rd	4th	5th/Last	Status	Due Date	Exemption
DTaP, DTP, DT, Td, Tdap (D-Diphtheria, T-Tetanus, P-Pertussis, aP-acellular Pertussis)								
Tdap Tdap or an inadvertent DTaP given on or after 10 years of age								
Polio (IPV or OPV)								
Haemophilus influenzae type b (Hib)								
Pneumococcal								
Measles, Mumps, and Rubella (MMR) 1st dose must be received on or after the 1st birthday								
Hepatitis B (HBV)								
Varicella (Chickenpox) 1st dose must be received on or after the 1st birthday.								
Hepatitis A (HAV) 1st dose must be received on or after the 1st birthday.								
Meningococcal Conjugate (ACWY)								

Immunization record received for this student is from:
☐ A statewide registry
☐ Student's former school
☐ Legally responsible individual of the student

Utah Department of Health
Division of Disease Control & Prevention
Immunization Program
Immunize.utah.gov
(801)-538-9450

Authorized Signature: ______________________________ **Date:**________________

Above signature is the signature of the school or health personnel who verified the Utah School Immunization Record (USIR) against the source record(s).

Rev. 06/2021

Instructions on how to complete the Utah School Immunization Record

All schools and early childhood programs must have a Utah School Immunization Record (USIR) for each enrolled student. The USIR must be completed by hand or printed from the Utah Statewide Immunization Information System (USIIS). For detailed information on the required immunizations and minimum intervals between vaccines doses, refer to the Utah Immunization Guidebook at immunize.utah.gov.

Instructions for Participating USIIS Users

The following fields will be automatically filled in on the USIR when printed by a participating USIIS User:

- **Student Information:** Student Name, Gender, Date of Birth**,** Name of Parent/Guardian (if entered on the Demographics page), USIIS ID, and PIN (a number that is given to an individual or a dependent's legal guardian, to obtain access to their immunization records in USIIS). The Student ID will only print when printed from a school that is enrolled in USIIS and has the students linked to that specific school.
- **Vaccine Information:** Dates of vaccines given (1st 2nd, 3rd, 4th, 5th/Last), Status and Due Date.

Completing the Form: Verify information is correct, print form, and fill in any of the necessary missing information below by hand or type.

- **Immunization Record Received For This Student:** Mark “A statewide registry”. If you used any other records for verification or missing information also mark “Student’s former school” and/or “Legally responsible individual of the student”.
- **Proof of Immunity (history of disease):** Fill in the status column with “Immunity” for a claim that a child has immunity against a disease which requires vaccination due to previously contracting the disease. A document that includes each antigen being claimed as immune (e.g., varicella, measles, rubella) and signed by a healthcare provider as proof of immunity must be attached to the USIR.
- **Exemption:** Fill in the exemption column with the type of exemption (religious, personal, or medical) if the student has an exemption. Attach a copy of the exemption form to the back of the USIR. For a medical exemption, a written notice signed by a licensed healthcare provider must also be attached to the USIR.
- **Authorized Signature/Date:** Sign and date – this is the signature of the school or health personnel who verified the USIR against the source record(s).

Instructions for Non-Participating USIIS Users or users who do not print USIR from USIIS

- **Student Information:** Fill in the Student Name, Gender, Date of Birth, and Name of Parent/Guardian.
  *NOTE - The USIIS ID, PIN, and Student ID are not required fields to be completed by facilities that are not enrolled in USIIS.
- **Vaccine Information:** Fill in the dates (month, day, and year in the appropriate column i.e., 1st, 2nd, 3rd, 4th, 5th/Last) for each of the required vaccines the student has received. Ensure these dates have been verified by a licensed healthcare professional, registered nurse, authorized representative of a local health department, and/or pharmacist that is on the immunization record(s) you received for that student.
  *NOTE – Status is only required to be completed if the student has a past history of disease such as chickenpox. Due Date is not a required field to be completed by facilities that are not enrolled in USIIS or do not print USIR from USIIS.
- **Immunization Record Received For This Student:** Mark the source of the record(s) used to complete this document.
- **Proof of Immunity (history of disease):** Fill in the status column with “Immunity” for a claim that a child has immunity against a disease which requires vaccination due to previously contracting the disease. A document that includes each antigen being claimed as immune (e.g., varicella, measles, rubella) and signed by a healthcare provider as proof of immunity must be attached to the USIR.
- **Exemption:** Fill in the exemption column with the type of exemption (religious, personal, or medical) if the student has an exemption. Attach a copy of the exemption form to the back of the USIR. For a medical exemption, a written notice signed by a licensed health care provider must also be attached to the USIR.
- **Authorized Signature/Date:** Sign and date – this is the signature of the school or health personnel who verified the USIR against the source record(s).

For further information, visit the Utah Immunization website at immunize.utah.gov or call 801-538-9450

WASATCH ACADEMY

Wasatch Academy 2023-24 School Year Travel Details

Please complete and return to the Student Travel Coordinator at travel@wasatchacademy.org

Student's Name: ______________________ Grade: ____ Phone: ______________________

Parent/Guardian Name: ______________________ Phone or Email: ______________________

Please email WA Student Transportation Coordinator Abbi Kennedy at travel@wasatchacademy.org with questions or concerns about your student's travel.

If your student is traveling as an unaccompanied minor please contact our Student Travel Coordinator, Abbi Kennedy immediately to set up pickup information with airlines. Abbi's email address is travel@wasatchacademy.org and phone number is 801.592.8062.

Beginning of School Arrival Information
Sunday, August 27th

My student requires transportation from **SALT LAKE CITY AIRPORT** to **WASATCH ACADEMY CAMPUS**

Sunday, August 27, 2023 Arrival Time: ________ Airline ____________ Flight #________ (before 8pm)

Connecting City: ______________

If Parent/Guardian is accompanying student to the school, please provide arrival details:

Arrival Date: ______________ and Approximate Arrival Time: ____________ (after 12 pm)

Fall Break
Saturday, October 7th–Sunday, October 15th (d*orms closed)*

Departure Information for Fall Break

My student requires transportation from **WASATCH ACADEMY CAMPUS** to the **SALT LAKE CITY AIRPORT**

Saturday, October 7, 2023 Departure Time: ________ Airline ________ Flight #________ (before 2:00 pm)

If Parent/Guardian is picking up student, please provide details for pick-up from campus:

Pick-Up Date: ______________ and Approximate Time of Pick-Up: ____________

Returning Information for Fall Break

Sunday, October 15, 2023 Arrival Time: ________ Airline ____________ Flight #________ (before 8pm)

Connecting City: ______________

If Parent/Guardian is accompanying student to the school, please provide arrival details:

Arrival Date: ______________ and Approximate Arrival Time: ____________

WASATCH ACADEMY

Wasatch Academy 2023-24 School Year Travel Details

Please complete and return to the Student Travel Coordinator at travel@wasatchacademy.org

Student's Name: ______________________ Grade: ____ Phone: ______________________

Parent/Guardian Name: ______________________ Phone or Email: ______________________

Please email WA Student Transportation Coordinator Abbi Kennedy at travel@wasatchacademy.org with questions or concerns about your student's travel.

If your student is traveling as an unaccompanied minor please contact our Student Travel Coordinator, Abbi Kennedy immediately to set up pickup information with airlines. Abbi's email address is travel@wasatchacademy.org and phone number is 801.592.8062.

Thanksgiving Break

Saturday, November 18th–Sunday, November 26th (dorms closed)

Departure Information for Thanksgiving Break

My student requires transportation from **WASATCH ACADEMY CAMPUS** to the **SALT LAKE CITY AIRPORT**

Saturday, November 18, 2023 Departure Time: ________ Airline ________ Flight # ________ (before 2:00 pm)

If Parent/Guardian is picking up student, please provide details for pick-up from campus:

Pick-Up Date: ______________ and Approximate Time of Pick-Up: ______________

Returning Information for Thanksgiving Break

Sunday, November 26, 2023 Arrival Time: ________ Airline ________ Flight # ________ (before 8pm)

Connecting City: ______________

If Parent/Guardian is accompanying student to the school, please provide arrival details:

Arrival Date: ______________ and Approximate Arrival Time: ______________

WASATCH ACADEMY

Wasatch Academy 2023-24 School Year Travel Details

Please complete and return to the Student Travel Coordinator at travel@wasatchacademy.org

Student's Name: ________________________ Grade: ____ Phone: ______________________________

Parent/Guardian Name: ________________________ Phone or Email: ______________________________

Please email WA Student Transportation Coordinator Abbi Kennedy at travel@wasatchacademy.org with questions or concerns about your student's travel.

If your student is traveling as an unaccompanied minor please contact our Student Travel Coordinator, Abbi Kennedy immediately to set up pickup information with airlines. Abbi's email address is travel@wasatchacademy.org and phone number is 801.592.8062.

Winter Break

Saturday, December 16th-Sunday, January 7th (*dorms closed*)

Departure Information for Winter Break

My student requires transportation from **WASATCH ACADEMY CAMPUS** to the **SALT LAKE CITY AIRPORT**

Saturday, December 16, 2023 Departure Time: ________ Airline ________ Flight #________ (before 2:00 pm)

If Parent/Guardian is picking up student, please provide details for pick-up from campus:

Pick-Up Date: __________________ and Approximate Time of Pick-Up: ________________

Returning Information for Winter Break

Sunday, January 7, 2024 Arrival Time: ________ Airline __________ Flight #________ (before 8pm)

Connecting City: ________________

If Parent/Guardian is accompanying student to the school, please provide arrival details:

Arrival Date: __________________ and Approximate Arrival Time: ________________

WASATCH ACADEMY

Wasatch Academy 2023-24 School Year Travel Details

Please complete and return to the Student Travel Coordinator at travel@wasatchacademy.org

Student's Name: ______________________ Grade: ____ Phone: ______________________

Parent/Guardian Name: ______________________ Phone or Email: ______________________

Please email WA Student Transportation Coordinator Abbi Kennedy at travel@wasatchacademy.org with questions or concerns about your student's travel.

If your student is traveling as an unaccompanied minor please contact our Student Travel Coordinator, Abbi Kennedy immediately to set up pickup information with airlines. Abbi's email address is travel@wasatchacademy.org and phone number is 801.592.8062.

March Break

Friday, March 1st-Monday, March 11th (dorms closed)

Departure Information for March Break

My student requires transportation from **WASATCH ACADEMY CAMPUS** to the **SALT LAKE CITY AIRPORT**

Friday, March 1, 2024 Departure Time: ________ Airline ________ Flight # ________ (before 2:00 pm)

If Parent/Guardian is picking up student, please provide details for pick-up from campus:

Pick-Up Date: ______________ and Approximate Time of Pick-Up: ______________

Returning Information for March Break

Monday, March 11, 2024 Arrival Time: ________ Airline ________ Flight # ________ (before 8pm)

Connecting City: ______________

If Parent/Guardian is accompanying student to the school, please provide arrival details:

Arrival Date: ______________ and Approximate Arrival Time: ______________

WASATCH ACADEMY

Wasatch Academy 2023-24 School Year Travel Details

Please complete and return to the Student Travel Coordinator at travel@wasatchacademy.org

Student's Name: ______________________ Grade: ____ Phone: ______________________

Parent/Guardian Name: ______________________ Phone or Email: ______________________

Please email WA Student Transportation Coordinator Abbi Kennedy at travel@wasatchacademy.org with questions or concerns about your student's travel.

If your student is traveling as an unaccompanied minor please contact our Student Travel Coordinator, Abbi Kennedy immediately to set up pickup information with airlines. Abbi's email address is travel@wasatchacademy.org and phone number is 801.592.8062.

End of School Year
Departure Information for Underclassmen – *All Students Except Seniors*
Thursday, May 16th

My student requires transportation from **WASATCH ACADEMY CAMPUS** to the **SALT LAKE CITY AIRPORT**

Thursday, May 16, 2024 Departure Time: ________ Airline ________ Flight #________ (before 2:00 pm)

If Parent/Guardian is picking up student, please provide details for pick-up from campus:

Pick-Up Date: ______________ and Approximate Time of Pick-Up: ______________

End of School Year
Departure Information for All Seniors
Saturday, May 18th

My student requires transportation from **WASATCH ACADEMY CAMPUS** to the **SALT LAKE CITY AIRPORT**

Saturday, May 18, 2024 Departure Time: ________ Airline ________ Flight #________ (After 6pm)