



# Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

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

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Birthdate (mm/dd/yyyy): \_\_\_\_\_ Sex: \_\_\_\_\_

Symbols below:   
 ◆ Required for School and Child Care/Preschool   
 ● Required for Child Care/Preschool Only

Parent/Guardian Name (please print): \_\_\_\_\_

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

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

Parent/Guardian Signature Required \_\_\_\_\_ Date \_\_\_\_\_

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

**1)  Chickenpox disease verified by printout from CHLD Profile Immunization Registry**  
Must be marked by printout (not by hand) to be valid.

**2)  Chickenpox disease verified by Health Care Provider (HCP)**  
If you choose this box, mark 2A OR 2B below.  
2A)  Signed note from HCP attached OR  
2B)  HCP signed here and print name below:

Licensed health care provider (HCP) Signature \_\_\_\_\_ Date \_\_\_\_\_  
(MD, DO, ND, PA, ARNP)  
HCP Printed Name: \_\_\_\_\_

**3)  Chickenpox disease verified by school staff from CHLD Profile Immunization Registry**  
If you choose this box, staff must initial that parent or guardian approves: \_\_\_\_\_ (initial) \_\_\_\_\_ (date)

**4)  Chickenpox disease verified by parent\***  
If you choose this box, fill in the date or child's age when he or she had the disease:  
Age/Date of disease: \_\_\_\_\_  
\*Can ONLY verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box. **Documentation of Disease Immunity**

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. Signed lab report(s) MUST also be attached.

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

Licensed health care provider (HCP) Signature \_\_\_\_\_ Date \_\_\_\_\_  
(MD, DO, ND, PA, ARNP)  
HCP Printed Name: \_\_\_\_\_

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Hepatitis B (Hep B)</b>				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
<b>Rotavirus (RV1, RV5)</b>				
	1			
	2			
	3			
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>				
	1			
	2			
	3			
	4			
	5			
<b>◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)</b>				
	1			
	2			
<b>● Haemophilus influenzae type b (Hib)</b>				
	1			
	2			
	3			
	4			
<b>● Pneumococcal (PCV, PPSV)</b>				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Polio (IPV, OPV)</b>				
	1			
	2			
	3			
	4			
<b>Influenza (flu, most recent)</b>				
<b>◆ Measles, Mumps, Rubella (MMR)</b>				
	1			
	2			
<b>◆ Varicella (chickenpox) or verify disease 1-4 ▶</b>				
	1			
	2			
<b>Hepatitis A (Hep A)</b>				
	1			
	2			
<b>Meningococcal (MCV, MPSV)</b>				
	1			
<b>Human Papillomavirus (HPV)</b>				
	1			
	2			
	3			
<b>Office Use Only:</b> Immunization information updated and verified with parent/guardian permission:				
Printed Staff Name	Date	Printed Staff Name	Date	
Printed Staff Name	Date	Printed Staff Name	Date	
Printed Staff Name	Date	Printed Staff Name	Date	

# Certificate of Exemption (COE)



From School, Child Care and Preschool Immunization Requirements<sup>1</sup>

DOH 348-106 Revised: 10/15/08

Child's Last Name:	First Name:	Middle Initial:	Child's Address:
Child's Birthdate:	Child's Sex:	Parent/Guardian Day Phone:	
Parent/Guardian Name:			

Please choose the exemption(s) that apply to your child as listed below.

<input type="checkbox"/> <b>Temporary Medical Exemption</b> <input type="checkbox"/> <b>Permanent Medical Exemption</b>	<input type="checkbox"/> <b>Personal/Philosophical Exemption</b> <input type="checkbox"/> <b>Religious Exemption</b>
<p>I certify that the child named on this form is medically exempted from the requirement for the following vaccine(s):</p> <p>Vaccine(s) _____ Until _____ Date (or Perm.) _____</p> <p>X _____ Type or Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP) _____ Date _____</p> <p>X _____ Signature of Licensed Health Care Provider _____ Date _____</p>	<p>I do not want my child to get the following vaccine(s).</p> <p><input type="checkbox"/> Diphtheria                      <input type="checkbox"/> Hepatitis B                      <input type="checkbox"/> Hib</p> <p><input type="checkbox"/> Measles                         <input type="checkbox"/> Mumps                             <input type="checkbox"/> Pertussis (whooping cough)</p> <p><input type="checkbox"/> Pneumococcal                <input type="checkbox"/> Polio                               <input type="checkbox"/> Rubella</p> <p><input type="checkbox"/> Tetanus                         <input type="checkbox"/> Varicella (chickenpox)</p> <p><input type="checkbox"/> Other (indicate): _____</p> <p>_____</p> <p>_____</p>

**Parent/Guardian Notice:** "I certify that the information provided here is correct and verifiable. I understand that if there is an outbreak of a vaccine-preventable disease my child has not been fully immunized against (as indicated above, for medical, personal/philosophical or religious reasons), my child may be at risk for disease and can be **excluded** from school, child care or preschool until the outbreak is over."

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

<sup>1</sup> RCW 28A.210.080-090 state that before or on the first day of every child's attendance at any public and private school or licensed day care center in Washington State 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. Medical exemptions must be signed by a licensed health care provider.