

Reviewed by: _____ Staff Signature	Date: _____
Is there an accompanying signed Certificate of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	



DOH 348-013
Rev: 10/15/08

Certificate of Immunization Status (CIS)

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

If completing by hand, write the vaccine in the row to the left of "Dose" and the date the vaccine was received in the "Date" column. Age column is optional.

◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only

Vaccine	Dose	Date	Age	Vaccine	Dose	Date	Age	Vaccine	Dose	Date	Age		
◆ Hepatitis B (Hep B)				● Pneumococcal (PCV, PPV)				Hepatitis A (Hep A)					
	1				1				1				
	2				2				2				
	3				3								
	4				4								
Hepatitis B (Hep B) Alternate schedule for teens				◆ Polio (IPV, OPV)				Meningococcal (MCV4, MPSV4)					
	1				1				1				
	2				2								
Rotavirus				Influenza (most recent)				Human Papillomavirus (HPV)					
	1				1				1				
	2				2				2				
	3				3				3				
	4				4								
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				◆ Measles, Mumps, Rubella (MMR)				Other					
	1				1								
	2				2								
	3												
	4												
	5												
◆ Diphtheria, Tetanus, Pertussis (Tdap, Td)				◆ Varicella (chickenpox)				<p>I certify that the information provided here is correct and verifiable.</p> <p>Signature of Parent or Guardian _____ Date _____</p> <p>Licensed HCP Signature (MD, DO, ND, PA, ARNP) _____ Date _____</p> <p>Either initial with parent approval or get parent signature below: Staff initials indicating parent approval: _____ Parent Signature indicating approval: _____</p>					
	1				1								
	2				2								
	3				3								
	4				4								
● Haemophilus influenzae type b (Hib)				<p>▼ Verification of varicella disease history ▼</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border: 1px solid black;"><input type="checkbox"/> Health Care Provider (HCP) Verified ▶</td> <td style="width: 50%; border: 1px solid black;"><input type="checkbox"/> Signed note from HCP attached or <input type="checkbox"/> HCP provider signature here: ▶</td> </tr> <tr> <td style="border: 1px solid black;"><input type="checkbox"/> HCP Verified by Registry ▶</td> <td style="border: 1px solid black;">No HCP Sig required if box at left checked. If school staff find verification in the Registry, then school staff must: ▶</td> </tr> <tr> <td style="border: 1px solid black;"><input type="checkbox"/> Parental Report ▶</td> <td style="border: 1px solid black;">ONLY acceptable for some grades. Write date or age child had disease:</td> </tr> </table>				<input type="checkbox"/> Health Care Provider (HCP) Verified ▶	<input type="checkbox"/> Signed note from HCP attached or <input type="checkbox"/> HCP provider signature here: ▶	<input type="checkbox"/> HCP Verified by Registry ▶	No HCP Sig required if box at left checked. If school staff find verification in the Registry, then school staff must: ▶	<input type="checkbox"/> Parental Report ▶	ONLY acceptable for some grades. Write date or age child had disease:
<input type="checkbox"/> Health Care Provider (HCP) Verified ▶	<input type="checkbox"/> Signed note from HCP attached or <input type="checkbox"/> HCP provider signature here: ▶												
<input type="checkbox"/> HCP Verified by Registry ▶	No HCP Sig required if box at left checked. If school staff find verification in the Registry, then school staff must: ▶												
<input type="checkbox"/> Parental Report ▶	ONLY acceptable for some grades. Write date or age child had disease:												
See the back of this page for documentation of immunity, a vaccine trade name reference guide, and a vaccine abbreviation list.													

Documentation of Immunity by Blood Test (titer)

I certify that the child named on this form has laboratory evidence of immunity to (check all that apply):

- Diphtheria Hepatitis A Hepatitis B Hib Measles Mumps Polio Rubella Tetanus Varicella
 Other (list): _____ lab report(s) attached (required)

X
 Typed or Printed Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X
 Signature of Licensed Health Care Provider (required) _____ Date (required) _____

CERTIFICATE OF EXEMPTION (COE): Please choose the exemption(s) that apply to your child as listed below.

Temporary Medical Exemption
 Permanent Medical Exemption

I certify that the child named on this form is medically exempted from the requirement for the following vaccine(s):

	Until
Vaccine(s)	Date (or Perm.)
X	
Type or Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)	
X	
Signature of Licensed Health Care Provider	Date

Personal/Philosophical Exemption
 Religious Exemption

I do not want my child to get the following vaccine(s).

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hib
<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Pertussis (whooping cough)
<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Polio	<input type="checkbox"/> Rubella
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Varicella (chickenpox)	

Other (indicate): _____

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 _____

¹ 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.