



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): _____

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

Parent/Guardian Signature Required _____ Date _____

Office Use Only:

Reviewed by: _____ Date: _____
 Signed Cert. of Exemption on file? Yes No

| Vaccine | Dose | 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, Td) | 1 | | | |
| | 2 | | | |
| ● Haemophilus influenzae type b (Hib) | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| | 4 | | | |
| ● Pneumococcal (PCV, PPSV) | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| | 4 | | | |

| Vaccine | Dose | Month | Day | Year |
|---|------|--------------------|------|------|
| ◆ Polio (IPV, OPV) | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| | 4 | | | |
| Influenza (flu, most recent) | | | | |
| | | | | |
| ◆ Measles, Mumps, Rubella (MMR) | 1 | | | |
| | 2 | | | |
| ◆ Varicella (chickenpox) or verify disease 1-4 | 1 | | | |
| | 2 | | | |
| Hepatitis A (Hep A) | | | | |
| | 1 | | | |
| | 2 | | | |
| Meningococcal (MCV, MPSV) | | | | |
| | 1 | | | |
| Human Papillomavirus (HPV) | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| Office Use Only: 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 | |

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 CHILD 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 CHILD 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.

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

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

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

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

| 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 |

#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 ▶

#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 has had chickenpox (varicella) disease and not the vaccine, use only one of these four options to record this on the CIS:

- 1) If your child's CIS is printed directly from the CHLD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
- 2) If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
- 3) If school staff access the CHLD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
- 4) If your child started kindergarten in the 2008-2009 school year or later, you CANNOT use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: <http://www.doh.wa.gov/cfr/immunize/schools/vaccine.htm>

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP 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 in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

| Trade Name | Vaccine | Trade Name | Vaccine | Trade Name | Vaccine | Trade Name | Vaccine | Trade Name | Vaccine |
|---------------|-------------|------------|------------|------------------|--------------------|-------------------|----------------------|-----------------|---------------|
| ActHIB | Hib | Engerix-B | Hep B | Ipol | IPV | Pentavalente | DTaP + Hep B + Hib | TriHibit | DTaP + Hib |
| Adacel | Tdap | Fluarix | Flu (TIV) | Infanrix | DTaP | Pneumovax | PPSV or PPV23 | Tripedia | DTaP |
| Afluria | Flu (TIV) | FluLaval | Flu (TIV) | Kinrix (Karr) | DTaP + IPV | Prevnar | PCV or PCV7 or PCV13 | Twinrix (Twnrx) | Hep A + Hep B |
| Boostrix | Tdap | FluMist | Flu (LAIV) | Menactra | MCV or MCV4 | ProQuad (PrOd) | MMR + Varicella | Vacita | Hep A |
| Cervarix | HPV2 | Fluvirin | Flu (TIV) | Menomune | MPSV or MPSV4 | Quadracel (Qdrcl) | DTaP + IPV | Varivax | Varicella |
| Comvax (Cmvx) | Hep B + Hib | Fluzone | Flu (TIV) | Pediarix (Fdrx) | DTaP + Hep B + IPV | Recombivax HB | Hep B | | |
| Daptacel | DTaP | Gardasil | HPV4 | PedvaxHIB | Hib | Rotarix | Rotavirus (RV1) | | |
| Decavac | Td | Havrix | Hep A | Pentacel (Pntcl) | DTaP + Hib + IPV | Rotarix | Rotavirus (RV5) | | |

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

(For updated lists, visit <http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf>)

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If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

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OPHI-10000000



DOH 348-106 June 2011

Certificate of Exemption

For School, Child Care and Preschool Immunization Requirements¹



DIRECTIONS: All exemptions must have a licensed health care provider sign & date Box 1 ('Provider Statement').² Exception: Box 1 is not required for religious exemptions when Box 2 ('Demonstration of Religious Membership') is completed. All exemptions must also have a parent/guardian sign & date Box 3 ('Parent/Guardian Statement').

| | | | | | |
|--------------------|-------------|-----------------|-------------------------|------|--------------------------------------|
| Child's Last Name: | First Name: | Middle Initial: | Birthdate (mm/dd/yyyy): | Sex: | Parent/Guardian Name (please print): |
|--------------------|-------------|-----------------|-------------------------|------|--------------------------------------|

Parent/Guardian, please choose the exemption(s) that apply to your child below.

- Temporary Medical Exemption
- Permanent Medical Exemption

- Personal/Philosophical Exemption (see Box 1)
- Religious Exemption (see Box 1)
- Religious Membership Exemption (see Box 2)

Vaccine(s) _____ Until _____ Date (or Permanent)

Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

Signature of Licensed Health Care Provider _____ X _____ Date

Box 1

Provider Statement²: "I, _____, am a qualified provider (MD, DO, ND, PA, ARNP) licensed under Title 18 RCW. I confirm that the parent or guardian signing in Box 3 (Parent/Guardian Statement) has received information on the benefits and risks of immunization to their child as a condition for exempting their child for medical, religious, personal, or philosophical reasons."

Signature of Licensed Health Care Provider (MD, DO, ND, PA, ARNP) _____ X _____ Date

Box 2

Parent/Guardian Demonstration of Religious Membership: "I am a member of a church or religious body whose beliefs or teachings do not allow for medical treatment from a health care practitioner. By supplying the information requested below, no further proof or signed provider statement in Box 1 is required for this religious exemption."

I do not want my child to get the following vaccine(s):
 Diphtheria Hepatitis B Hib
 Measles Mumps Pertussis (whooping cough)
 Pneumococcal Polio Rubella
 Tetanus Varicella (chickenpox)
 Other (indicate): _____

Name of Church or Religious Body _____ X _____ Date
 Signature of Parent or Guardian _____ X _____ Date

Box 3

Parent/Guardian Statement: "I certify that all the information provided on this certificate 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 or Guardian _____ X _____ Date

If you have a disability and need this document in a different format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

¹ RCW 28A.210.080-090 states that 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 a licensed health care provider.

² A letter may substitute for a signed 'Provider Statement' on this certificate. To be accepted, the letter must reference the child's name on this certificate, confirm that the child's parent or guardian got information on the risks and benefits of immunization to their child, and be signed by a licensed health care provider.