

Reviewed for compliance by: _____
 Staff Signature
 Date: _____ Exemption: YES NO
 (see back)



CERTIFICATE OF IMMUNIZATION STATUS

Washington State Law (RCW 28A.210.160) requires that all children have a completed Certificate of Immunization Status on file at the school, preschool or a child care facility that they attend.

Child's Last Name	First Name	Middle Name	Sex	Birthdate
Parent/Guardian Name			Daytime Phone	

Immunization	Type of Vaccine	Dose	Date Given		
			Month	Day	Year
HEP B (HBV) Hepatitis B		1			
		2			
		3			
		4			
DTaP/DTP/DT Diphtheria, Tetanus, Pertussis		1			
		2			
		3			
		4			
		5			
		6			
Td/Tdap		1			
		2			
		3			
HIB Haemophilus Influenzae B		1			
		2			
		3			
		4			
POLIO OPV (by mouth) IPV (by injection)		1			
		2			
		3			
		4			
		5			

Immunization	Type of Vaccine	Dose	Date Given		
			Month	Day	Year
MMR Measles (Rubeola), Mumps & Rubella	MMR	1			
	MMR	2			
	MMR				
	MEASLES				
	MUMPS				
	RUBELLA				
VARICELLA (Chickenpox)	VACCINE	1			
		2			
	DISEASE	YES		NO	
	Approximate date or age at time of disease				
OTHER VACCINES					

➔ I certify that the information provided here is correct and verifiable ←

X _____ Date: _____
 Signature of Parent or Guardian

Statement of Exemption to Immunization Law

NOTICE:

Your Child can be exempted (excused) from immunization for medical, personal or religious reasons. However, if there is an outbreak of a vaccine-preventable disease that your child has not been immunized against, she or he can be excluded from school, preschool or child care until the outbreak is over.

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

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

_____ Date
Licensed Health Care Provider Signature

Personal Exemption **Religious Exemption**

I am opposed to immunization. I understand that my child can be excluded from attendance during an outbreak.

I do not want my child to receive the following vaccine(s):

Vaccine(s)

_____ Date
Signature of Parent or Guardian

Documentation of Immunity

I certify that the child named on this form has laboratory evidence of immunity to measles/mumps/rubella/varicella.
(please circle)

Attach TITER results

TYPE or PRINT Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

_____ Date
Licensed Health Care Provider's Signature or Stamp

For More Information

<http://www.cdc.gov/nip/recs/child-schedule.htm#Printable>

<http://www.doh.wa.gov/cfh/immunize/schools.htm>