



Is there an accompanying signed Certificate of Exemption on file?
 Yes No

Reviewed by: _____ Date: _____
Staff Signature

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
♦ Hepatitis B (Hep B)							
	1			Hepatitis A (Hep A)	1		
	2				2		
	3						
Hepatitis B (Hep B) Alternate schedule for teens							
	1			Meningococcal (MCV4, MPSV4)	1		
	2						
Rotavirus							
	1			Human Papillomavirus (HPV)	1		
	2				2		
	3				3		
♦ Diphtheria, Tetanus, Pertussis (DTaP, DT)							
	1			Other			
	2						
	3						
	4						
	5						
♦ Diphtheria, Tetanus, Pertussis (Tdap, Td)							
	1						
	2						
♦ Haemophilus influenzae type b (Hib)							
	1						
	2						
	3						
	4						
I certify that the information provided here is correct and verifiable.							
Signature of Parent or Guardian							Date
Verification of varicella disease history ▼ <input type="checkbox"/> Health Care Provider (HCP) Verified <input type="checkbox"/> Signed note from HCP attached or HCP provider signature here: _____ <input type="checkbox"/> HCP Verified by Receipt <input type="checkbox"/> If school staff find varicella verification in the Registry, then school staff must: _____ <input type="checkbox"/> Parental Report <input type="checkbox"/> 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.							
Licensee HCP Signature (MD, DO, ND, PA, APRN) _____ Date _____ Either initial with parent approval or get parent signature below. Staff Initials indicating parent approval: _____ Parent Signature indicating approval: _____							

Certificate of Exemption (COE)

From School, Child Care and Preschool Immunization Requirements¹



DOH 348-106 Revised: 10/15/03

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

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):

Vaccine(s)	Unit	Date (or Perm.)
X		
Type or Print Name of Licensed Health Care Provider (MD, DO, ND, PA, NP, etc.)		
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).

- Diphtheria
- Measles
- Pneumococcal
- Tetanus
- Hepatitis B
- Mumps
- Polio
- Varicella (chickenpox)
- Hib
- Pertussis (whooping cough)
- Rubella
- 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.