Reviewed for compliance	e by:				
	S	Staff Sig	nature		
Date:	Exemption:	YES		NO \square	
(see back)					

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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				st Name		Middle Name		Sex	Birthdate		
Parent/Guardian Name							Daytime Pho	one			
	Type of	pe of Date Given		en en		Type of		Date Given			
Immunization	Vaccine	Dose	Month	Day	Year	Immunization	Vaccine	Dose	Month	Day	Year
HEP B		1				MMR	MMR	1			
(HBV) Hepatitis B		2				<u>M</u> easles (Rubeola),	MMR	2			
		3				<u>M</u> umps & <u>R</u> ubella	MMR				
		4					MEASLES				
		1					MUMPS				
DTaP/DTP/		2					RUBELLA				
DT		3				VARICELLA	VACCINE	1			
		4						2			
Diphtheria, Tetanus, Pertussis		5				(Chickenpox)	DISEASE	YES		NO	
		6					Approximate date or age at time of disease				
,		1				0	THER V	ACC	NES		
Td/Tdap		2									

	→ I certify that the information provided here is correct and verifiable ←
X _	Date:
	Signature of Parent or Guardian

HIB

Haemophilus

Influenzae B

POLIO

OPV (by mouth) IPV (by injection)

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	s):			
Until				
Type or Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)				
Licensed Health Care Provider Signature Date				
☐ 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)				
Signature of Parent or Guardian Date				
Documentation of Immunity				
I certify that the child named on this form has laboratory evidence of immunity to measles/mumps/rubella/varice	ella.			
(please circle) Attach TITER results				
TYPE or PRINT Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)				
Licensed Health Care Provider's Signature or Stamp				

For More Information

http://www.doh.wa.gov/cfh/lmmunize/documents/childschedule05.pdf

http://www.doh.wa.gov/cfh/lmmunize/schools.htm