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

Washington State Department of Health

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)

_____

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/varicella.
(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 Date

For More Information

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

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