



# Certificate of Immunization Status (CIS)

For Kindergarten-12<sup>th</sup> Grade / Child Care Entry

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_  
 Office Use Only:  
 Signed Cert. of Exemption on file?  Yes  No

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

**Child's Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Birthdate (MM/DD/YY):** \_\_\_\_\_ **Sex:** \_\_\_\_\_

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

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

**Parent/Guardian Signature Required** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Signature Required** \_\_\_\_\_ **Date** \_\_\_\_\_

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
<b>Required Vaccines for School or Child Care Entry</b>					
◆ DTaP / DT (Diphtheria, Tetanus, Pertussis)					
◆ Tdap (Tetanus, Diphtheria, Pertussis)					
◆ Td (Tetanus, Diphtheria)					
◆ Hepatitis B <input type="checkbox"/> 2-dose schedule used between ages 11-15					
● Hib ( <i>Haemophilus influenzae</i> type b)					
◆ IPV / OPV (Polio)					
◆ MMR (Measles, Mumps, Rubella)					
● PCV / PPSV (Pneumococcal)					
◆ Varicella (Chickenpox) <input type="checkbox"/> History of disease verified by IIS					
<b>Recommended Vaccines (Not Required for School or Child Care Entry)</b>					
Flu (Influenza)					
Hepatitis A					
HPV (Human Papillomavirus)					
MCV / MPSV (Meningococcal)					
MenB (Meningococcal)					
Rotavirus					

**Documentation of Disease Immunity**  
*Healthcare provider use only*

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it **MUST** be verified by a healthcare provider

I certify that the child named on this CIS has:

a verified history of Varicella (Chickenpox).  
 laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	_____
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	_____

Licensed healthcare provider signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)

Printed Name \_\_\_\_\_