

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
<b>HEP B</b> (HBV) Hepatitis B		1			
		2			
		3			
		4			
<b>DTaP/DTP/DT</b>  Diphtheria, Tetanus,  Pertussis		1			
		2			
		3			
		4			
		5			
		6			
<b>Td/Tdap</b>		1			
		2			
		3			
<b>HIB</b> Haemophilus Influenzae B		1			
		2			
		3			
		4			
<b>POLIO</b> OPV (by mouth) IPV (by injection)		1			
		2			
		3			
		4			
		5			

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

➔ 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.doh.wa.gov/cfh/Immunize/documents/childschedule05.pdf>

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