



Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Reviewed by: _____ Date: _____
 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.

Parent/Guardian Signature Required _____ **Date** _____

Parent/Guardian Signature Required _____ **Date** _____

Required Vaccines for School or Child Care Entry	Date	Date	Date	Date	Date
Required Vaccines (Not Required for School or Child Care Entry)	Date	Date	Date	Date	Date
◆ 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					
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 _____

Printed Name _____