

COLUMBIA SCHOOL DISTRICT NO. 400 STUDENT REGISTRATION FORM

DO NOT WRITE IN SHADED AREA FOR OFFICE USE ONLY	STUDENT SCHOOL NUMBER	SCHOOL ENTRY DATE	LOCKER NUMBER	LUNCH #
HOMEROOM NUMBER	BIRTH CERTIFICATE	IMMUNIZATION COMPLETE	MEDICAL ALERT	

STUDENT NAME: Legal Last Name	Legal First Name	Legal Middle Name	Also known as:
BIRTHDATE (Month/Day/Year)	GENDER (M/F)	BIRTHPLACE: City State Country	GRADE LEVEL
ETHNIC CODE (Check One) <input type="checkbox"/> A-Asian or Pacific Islander <input type="checkbox"/> B-Black, not of Hispanic Origin <input type="checkbox"/> H-Hispanic		<input type="checkbox"/> I-American Indian or Alaska Native <input type="checkbox"/> White, not of Hispanic Origin <input type="checkbox"/> Other	
PRIMARY LANGUAGE SPOKEN AT HOME		US CITIZEN	
Did you move to this area for the purpose of finding work such as farm equipment operation or food processing? <input type="checkbox"/> YES <input type="checkbox"/> NO			

PRIMARY HOUSEHOLD (parent/guardian where student resides) <i>Last Name First</i> Employer:	PHONE – Home Phone (include area code) <input type="checkbox"/> Please check if unlisted	PHONE – Work Phone (include area code) PHONE – Cell Phone (include area code)	STUDENT LIVES WITH <input type="checkbox"/> Both Parents <input type="checkbox"/> Father Only <input type="checkbox"/> Mother Only <input type="checkbox"/> Grandparents <input type="checkbox"/> Father/Stepmother <input type="checkbox"/> Mother/Stepfather <input type="checkbox"/> Stepfather/Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Agency <input type="checkbox"/> Self <input type="checkbox"/> Other
(parent/guardian where student resides) <i>Last Name First</i> Employer:	PHONE – Home Phone (include area code) <input type="checkbox"/> Please check if unlisted	PHONE – Work Phone (include area code) PHONE – Cell Phone (include area code)	
RESIDENT ADDRESS <i>Street</i>	Apt. #	City State Zip	
MAILING ADDRESS (if different from above) <i>Street</i>	Apt. #	PO Box	City State Zip

SECOND HOUSEHOLD (non-custodial parent not residing with student) <i>Last Name First Name</i>	PHONE # (include area code) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	PHONE # (include area code) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Relationship:
(non-custodial parent not residing with student) <i>Last Name First Name</i>	PHONE # (include area code) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	PHONE # (include area code) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Relationship:
SECOND HOUSEHOLD (street/PO Box, City, State, Zip)			Additional Mailing Requested <input type="checkbox"/> Yes <input type="checkbox"/> No

IS THERE A JOINT-CUSTODY OR PARENTING PLAN IN EFFECT? YES NO (If yes, plan must be on file with the school for enforcement)

IS THERE A RESTRATINING ORDER IN EFFECT? YES NO (If yes, legal papers must be on file with the school for enforcement)

Restraining order is against Mother Father Other _____

SCHOOL PREVIOUSLY ATTENDED	SCHOOL PHONE # SCHOOL FAX#	PREVIOUS SCHOOL ADDRESS (Street/PO Box, City, State, Zip)
HAS STUDENT EVER ATTENDED COLUMBIA SCHOOLS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF SCHOOL	Dates Attended (Month/Year)
HAS STUDENT EVER BEEN SUSPENDED FOR A WEAPONS VIOLATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, Date:	

HAS YOUR CHILD EVER QUALIFIED FOR, OR BEEN ENROLLED IN A SPECIAL EDUCATION PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO HAS YOUR CHILD EVER QUALIFIED FOR, OR HAD A 504 PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO HAS YOUR CHILD EVER PARTICIPATED IN <input type="checkbox"/> Title <input type="checkbox"/> LAP <input type="checkbox"/> Gifted <input type="checkbox"/> ESL <input type="checkbox"/> Other _____	HAS YOUR CHILD EVER BEEN RETAINED? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, at what grade level(s)? _____
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VERIFICATION OF INFORMATION: The information on this form is true and accurate as of this date. I understand that falsification of information to achieve enrollment or assignment may be cause for revocation of the student's enrollment or assignment to a school in the Columbia School District.

Legal Parent/Guardian Signature _____ Date _____

Additional registration information on back

DOES STUDENT ATTEND CHILD CARE? <input type="checkbox"/> Before School <input type="checkbox"/> After School <input type="checkbox"/> Before & After School <input type="checkbox"/> Not Applicable	CHILD CARE PROVIDER: <i>Name</i> <i>Address</i> <i>Phone Number</i>
ADDITIONAL CHILD CARE ARRANGEMENTS (Please provide information to school in writing)	

PLEASE LIST OTHER SIBLINGS ATTENDING COLUMBIA SCHOOLS		
<i>Last Name</i>	<i>First Name</i>	<i>School</i>

SPECIAL INSTRUCTIONS REGARDING RELIGIOUS BELIEFS (Please provide information to school in writing)

ANY ALLERGIES OR OTHER HEALTH CONCERNS? <input type="checkbox"/> Allergies (please specify) <input type="checkbox"/> Diabetes <input type="checkbox"/> Glandular Problems <input type="checkbox"/> Neoplasma/Cancer <input type="checkbox"/> Respiratory <input type="checkbox"/> Vision Problems <input type="checkbox"/> Hearing Loss <input type="checkbox"/> PE Considerations <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Skeletal Limitations <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other:	PHYSICIANS NAME PHYSICIANS PHONE #
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PLEASE LIST CURRENT MEDICATIONS, IF ANY: <i>Important: If medication is to be taken during school hours, a signed <u>Authorization for Administration of Oral Medication Taken at School</u> must be on file. All prescriptions and Over-The-Counter medications are to be kept in the school office.</i>

EMERGENCY MEDICAL AUTHORIZATION: I understand that in the event of accident or illness, every effort will be made to contact parent/guardian immediately. If parent/guardian cannot be reached, I authorize school authorities to obtain emergency care for my child.

► *Legal Parent/Guardian Signature* _____ *Date:* _____

Please initial here if you do not wish to have your student's photo used in any medium, including the school yearbook.

When injury, illness or other non-emergency situations occur involving your child, we want to be able to quickly reach families or other responsible adults. In the event we cannot reach a parent/guardian, please list persons you trust who are available during the day to provide care for your child.

PRIMARY CONTACT (other than parent/guardian) <i>Last Name</i> <i>First Name</i>	RELATIONSHIP TO CHILD	PHONE # (include area code) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	PHONE #2 (include area code) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
PRIMARY CONTACT ADDRESS <i>Street</i>		<i>City</i>	<i>State</i> <i>Zip</i>
SECONDARY CONTACT (other than parent/guardian) <i>Last Name</i> <i>First Name</i>	RELATIONSHIP TO CHILD	PHONE # (include area code) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	PHONE #2 (include area code) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
PRIMARY CONTACT ADDRESS <i>Street</i>		<i>City</i>	<i>State</i> <i>Zip</i>

STUDENT RELEASE AUTHORIZATION: In the event that the school is unable to contact the parent/guardian, I authorize that my child may be released to the person(s) listed above.

► *Legal Parent/Guardian Signature* _____ *Date:* _____

FIELD TRIP PERMISSION: I give my child permission to attend school sponsored field trips.

► *Legal Parent/Guardian Signature* _____ *Date:* _____

Sample Ethnicity and Race Data Collection Form 01/28/10

QUESTION 1. Is your child of Hispanic or Latino origin? (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> NOT HISPANIC/LATINO
<input type="checkbox"/> CUBAN
<input type="checkbox"/> DOMINICAN
<input type="checkbox"/> SPANIARD
<input type="checkbox"/> PUERTO RICAN | <input type="checkbox"/> MEXICAN/ MEXICAN AMERICAN/ CHICANO
<input type="checkbox"/> CENTRAL AMERICAN
<input type="checkbox"/> SOUTH AMERICAN
<input type="checkbox"/> LATIN AMERICAN
<input type="checkbox"/> OTHER HISPANIC/LATINO |
|--|--|

QUESTION 2. What race(s) do you consider your child? (Check all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> AFRICAN AMERICAN/ BLACK

<input type="checkbox"/> WHITE

<input type="checkbox"/> ASIAN INDIAN
<input type="checkbox"/> CAMBODIAN
<input type="checkbox"/> CHINESE
<input type="checkbox"/> FILIPINO
<input type="checkbox"/> HMONG
<input type="checkbox"/> INDONESIAN
<input type="checkbox"/> JAPANESE
<input type="checkbox"/> KOREAN
<input type="checkbox"/> LAOTIAN
<input type="checkbox"/> MALAYSIAN
<input type="checkbox"/> PAKISTANI
<input type="checkbox"/> SINGAPOREAN
<input type="checkbox"/> TAIWANESE
<input type="checkbox"/> THAI
<input type="checkbox"/> VIETNAMESE
<input type="checkbox"/> OTHER ASIAN

<input type="checkbox"/> NATIVE HAWAIIAN
<input type="checkbox"/> FIJIAN
<input type="checkbox"/> GUAMANIAN or CHAMORRO
<input type="checkbox"/> MARIANA ISLANDER
<input type="checkbox"/> MELANESIAN
<input type="checkbox"/> MICRONESIAN
<input type="checkbox"/> SAMOAN
<input type="checkbox"/> TONGAN
<input type="checkbox"/> OTHER PACIFIC ISLANDER | <input type="checkbox"/> ALASKA NATIVE
<input type="checkbox"/> CHEHALIS
<input type="checkbox"/> COLVILLE
<input type="checkbox"/> COWLITZ
<input type="checkbox"/> HOH
<input type="checkbox"/> JAMESTOWN
<input type="checkbox"/> KALISPEL
<input type="checkbox"/> LOWER ELWHA
<input type="checkbox"/> LUMMI
<input type="checkbox"/> MAKAH
<input type="checkbox"/> MUCKLESHOOT
<input type="checkbox"/> NISQUALLY
<input type="checkbox"/> NOOKSACK
<input type="checkbox"/> PORT GAMBLE KLALLAM
<input type="checkbox"/> PUYALLUP
<input type="checkbox"/> QUILEUTE
<input type="checkbox"/> QUINAULT
<input type="checkbox"/> SAMISH
<input type="checkbox"/> SAUK-SUIATTLE
<input type="checkbox"/> SHOALWATER
<input type="checkbox"/> SKOKOMISH
<input type="checkbox"/> SNOQUALMIE
<input type="checkbox"/> SPOKANE
<input type="checkbox"/> SQUAXIN ISLAND
<input type="checkbox"/> STILLAGUAMISH
<input type="checkbox"/> SUQUAMISH
<input type="checkbox"/> SWINOMISH
<input type="checkbox"/> TULALIP
<input type="checkbox"/> YAKAMA
<input type="checkbox"/> OTHER WASHINGTON INDIAN
<input type="checkbox"/> OTHER AMERICAN INDIAN |
|---|--|



Office of Superintendent of Public Instruction (OSPI)
Washington State Transitional Bilingual Instructional Program
Home Language Survey

Student Name:			Date:
Birth Date:	Gender:	Grade:	SSID:
Form Completed by:			
Parent/Guardian Name _____ Relationship to Student _____			
Parent/Guardian Signature _____			
If available, in what language would you prefer to receive communication from the school? _____			
Did your child receive English language development support through the Transitional Bilingual Instruction Program in the last school your child attended? Yes__ No__ Don't Know__			

1. In what country was your child born?	_____
2. What language did your child first learn to speak?*	_____
3. What language does <u>YOUR CHILD</u> use the most at home?*	_____
4. What language(s) do <u>parent/guardians</u> use the most when you speak to your child?	_____ _____
5. Has your child ever attended a school outside of the United States? ____ Yes ____ No	If yes, in what language(s) was instruction given? _____ For how many months? ____
6. Has your child attended school in the United States before enrolling in this district? (Kindergarten – 12 th grade) ____ Yes ____ No	For how many months? _____ months *One (1) school year = 10 months
7. Do grandparent(s) or parent(s) have a tribal affiliation? ____ Yes ____ No	

*WAC 392-160-005: "Primary language" means the language most often used by a student (not necessarily by parents, guardians, or others) for communication in the student's place of residence.



Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Office Use Only:	
Reviewed by: _____	Date: _____
Signed Cert. of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

Child's Last Name: _____	First Name: _____	Middle Initial: _____	Birthdate (mm/dd/yyyy): _____	Sex: _____	I certify that the information provided on this form is correct and verifiable.
Symbols below: ◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only				Parent/Guardian Name (please print): _____	

Vaccine	Dose	Date		
		Month	Day	Year
◆ Hepatitis B (Hep B)				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)				
	1			
	2			
● Haemophilus influenzae type b (Hib)				
	1			
	2			
	3			
	4			
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date		
		Month	Day	Year
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox) or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			
Office Use Only: Immunization information updated and verified with parent/guardian permission:				
Printed Staff Name _____		Date _____		
Printed Staff Name _____		Date _____		

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

1) Chickenpox disease verified by printout from CHILD Profile Immunization Registry
Must be marked by printout (not by hand) to be valid.

2) Chickenpox disease verified by Health Care Provider (HCP)
If you choose this box, mark 2A OR 2B below.
 2A) Signed note from HCP attached OR
 2B) HCP signed here and print name below:

 Licensed health care provider (HCP) Signature _____ Date _____
 (MD, DO, ND, PA, ARNP)
 HCP Printed Name: _____

3) Chickenpox disease verified by school staff from CHILD Profile Immunization Registry
If you choose this box, staff must initial that parent or guardian approves: _____ (initial) _____ (date)

4) Chickenpox disease verified by parent*
If you choose this box, fill in the date or child's age when he or she had the disease:
 Age/Date of disease: _____
 *Can ONLY verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.
Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. **Signed lab report(s) 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 health care provider (HCP) Signature _____ Date _____
 (MD, DO, ND, PA, ARNP)
 HCP Printed Name: _____

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

Vaccine	Dose	Date		
		Month	Day	Year
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
DTaP	1	01	12	2011
DTaP	2	03	20	2011
DTaP	3	06	01	2011

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

- 1) If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
- 2) If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
- 3) If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
- 4) If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: <http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm>

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Vaccine Trade Names in alphabetical order									
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menaetra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqa	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrel)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order							
DT	Diphtheria, Tetanus	Hep A (HAV)	Hepatitis A	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B (HBV)	Hepatitis B	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	Hib	<i>Haemophilus influenzae</i> type b	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	HPV	Human Papillomavirus	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

2010-05-10

Certificate of Exemption

For School, Child Care and Preschool Immunization Requirements¹



DIRECTIONS: All exemptions must have a licensed health care provider sign & date Box 1 ('Provider Statement').² Exception: Box 1 is not required for religious exemptions when Box 2 ('Demonstration of Religious Membership') is completed. All exemptions must also have a parent/guardian sign & date Box 3 ('Parent/Guardian Statement').

Child's Last Name:	First Name:	Middle Initial:	Birthdate (mm/dd/yyyy):	Sex:	Parent/Guardian Name (please print):
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Parent/Guardian, please choose the exemption(s) that apply to your child below.

<input type="checkbox"/> Temporary Medical Exemption <input type="checkbox"/> Permanent Medical Exemption <hr/> Vaccine(s) _____ Until _____ Date (or Permanent) <hr/> Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP) <hr/> X _____ X _____ Signature of Licensed Health Care Provider Date	<input type="checkbox"/> Personal/Philosophical Exemption (see Box 1) <input type="checkbox"/> Religious Exemption (see Box 1) <input type="checkbox"/> Religious Membership Exemption (see Box 2) I do not want my child to get the following vaccine(s): <input type="checkbox"/> Diphtheria <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hib <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Pertussis (whooping cough) <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Polio <input type="checkbox"/> Rubella <input type="checkbox"/> Tetanus <input type="checkbox"/> Varicella (chickenpox) <input type="checkbox"/> Other (indicate): _____
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Box 1
<p>Provider Statement²: "I, _____, am a qualified provider (MD, DO, ND, PA, ARNP) licensed under Title 18 RCW. I confirm that the parent or guardian signing in Box 3 (Parent/Guardian Statement) has received information on the benefits and risks of immunization to their child as a condition for exempting their child for medical, religious, personal, or philosophical reasons." X _____ Signature of Licensed Health Care Provider (MD, DO, ND, PA, ARNP) X _____ Date</p>

Box 2
<p>Parent/Guardian Demonstration of Religious Membership: "I am a member of a church or religious body whose beliefs or teachings do not allow for medical treatment from a health care practitioner. By supplying the information requested below, no further proof or signed provider statement in Box 1 is required for this religious exemption." X _____ Name of Church or Religious Body X _____ X _____ Signature of Parent or Guardian Date</p>

Box 3
<p>Parent/Guardian Statement: "I certify that all the information provided on this certificate is correct and verifiable. I understand that if there is an outbreak of a vaccine-preventable disease my child has not been fully immunized against (as indicated above, for medical, personal/philosophical or religious reasons), my child may be at risk for disease and can be excluded from school, child care, or preschool until the outbreak is over." X _____ X _____ Signature of Parent or Guardian Date</p>

If you have a disability and need this document in a different format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

¹ RCW 28A.210.080-090 states that before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the State Board of Health, or (3) a certificate of exemption, signed by a parent or guardian and a licensed health care provider.

² A letter may substitute for a signed 'Provider Statement' on this certificate. To be accepted, the letter must reference the child's name on this certificate, confirm that the child's parent or guardian got information on the risks and benefits of immunization to their child, and be signed by a licensed health care provider.