Columbia School District No. 400
STUDENT INFORMATION

Teacher: ______________________ **Grade:** ______________

Student: ____
Last *First* *Middle*

Street Address: ______________________________________

City: ______________________ **State:** ________ **Zip:** __________

PO Box: __________ **City:** ______________ **State:** ________ **Zip:** __________

Birth Date: __________ **Birth Place** __________ **Birth Country:** __________

Mother's Name ______________________ **Home Phone:** __________

Address: ______________________________________

Employer: ______________________ **Can mother be reached at work?** ________

Work Phone: ______________ **Cell Phone:** __________

Father's Name ______________________ **Home Phone:** __________

Address: ______________________________________

Employer: ______________________ **Can father be reached at work?** ________

Work Phone: ______________ **Cell Phone:** __________

Daycare Provider: ______________________ **Phone:** __________

Address: ______________________________________

Parents are always called first in the event of illness or accident. Please list two other LOCAL emergency names and phone numbers.

1. ______________________________ **Phone:** __________

2. ______________________________ **Phone:** __________

♦ List any allergies or special things the school should be aware of: __________________

♦ If your child CANNOT be photographed please sign your name here: __________________

♦ I give my child permission to attend school sponsored field trips. In case of an emergency I authorize the school to seek immediate medical attention for my child.

Parent Signature: ______________________

Physicians Name: ______________________ **Phone:** __________

COLUMBIA ELEMENTARY SCHOOL
Before and After School Transportation Information

Please fill out and return to your child's teacher or school office.

Child's Name: ____
Last *First*

Address: ____

City: ______________________ State: ________________ Zip: ____________

Parent(s) or Guardian(s)

Name: ____________________________ Home Phone #: ________________

Cell #: ____________________________ Work Phone #: ________________

Name: ____________________________ Home Phone #: ________________

Cell #: ____________________________ Work Phone #: ________________

Daycare:

Name: ____

Address: ____

City: ______________________ State: ________________ Zip: ____________

Phone # ______________________

Transportation:

Coming to School (please check one)

☐ Ride bus from HOME ☐ Ride bus from DAYCARE ☐ Walk

AFTER SCHOOL (please check one)

☐ Ride bus from HOME ☐ Ride bus from DAYCARE ☐ Walk

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	IMMUNICATION 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) ☐ A-Asian or Pacific Islander ☐ B-Black, not of Hispanic Origin ☐ H-Hispanic ☐ I-American Indian or Alaska Native ☐ White, not of Hispanic Origin ☐ 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? ☐ YES ☐ NO

PRIMARY HOUSEHOLD (parent/guardian where student resides) *Last Name* *First* *Employer*:	PHONE – Home Phone (include area code) ☐ Please check if unlisted	PHONE – Work Phone (include area code) PHONE – Cell Phone (include area code)	STUDENT LIVES WITH ☐ Both Parents ☐ Father Only ☐ Mother Only ☐ Grandparents ☐ Father/Stepmother ☐ Mother/Stepfather ☐ Stepfather/Stepmother ☐ Guardian ☐ Agency ☐ Self ☐ Other
(parent/guardian where student resides) *Last Name* *First* *Employer*:	PHONE – Home Phone (include area code) ☐ Please check if unlisted	PHONE – Work Phone (include area code) PHONE – Cell Phone (include area code)	

RESIDENT ADDRESS *Street*	Apt. #		City State Zip
MAILING ADDRESS (if different from above) *Street*	Apt. #	PO Box	City State Zip

SECOND HOUSEHOLD (non-custodial parent not residing with student) *Last Name* *First Name*	PHONE # (include area code) ☐ Home ☐ Work ☐ Cell	PHONE # (include area code) ☐ Home ☐ Work ☐ Cell	Relationship:
(non-custodial parent not residing with student) *Last Name* *First Name*	PHONE # (include area code) ☐ Home ☐ Work ☐ Cell	PHONE # (include area code) ☐ Home ☐ Work ☐ Cell	Relationship:
SECOND HOUSEHOLD (street/PO Box, City, State, Zip)			Additional Mailing Requested ☐ Yes ☐ 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? ☐ YES ☐ NO IF YES, NAME OF SCHOOL		Dates Attended (Month/Year)
HAS STUDENT EVER BEEN SUSPENDED FOR A WEAPONS VIOLATION? ☐ YES ☐ NO		If Yes, Date:

HAS YOUR CHILD EVER QUALIFIED FOR, OR BEEN ENROLLED IN A SPECIAL EDUCATION PROGRAM? ☐ YES ☐ NO

HAS YOUR CHILD EVER QUALIFIED FOR, OR HAD A 504 PLAN? ☐ YES ☐ NO

HAS YOUR CHILD EVER PARTICIPATED IN ☐ Title ☐ LAP ☐ Gifted ☐ ESL ☐ Other ___________________

HAS YOUR CHILD EVER BEEN RETAINED? ☐ YES ☐ NO

If yes, at what grade level(s)? _________________

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?	**CHILD CARE PROVIDER:** *Name* *Address* *Phone Number*
☐ **Before School** ☐ **After School** ☐ **Before & After School** ☐ **Not Applicable**	
ADDITIONAL CHILD CARE ARRANGEMENTS (Please provide information to school in writing)	

PLEASE LIST OTHER SIBLINGS ATTENDING COLUMBIA SCHOOLS

Last Name *First Name*	*School*	*Grade*

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

ANY ALLERGIES OR OTHER HEALTH CONCERNS?				**PHYSICIANS NAME**
☐ **Allergies (please specify)**	☐ **Diabetes**	☐ **Glandular Problems**	☐ **Neoplasma/Cancer**	
☐ **Respiratory**	☐ **Vision Problems**	☐ **Hearing Loss**	☐ **PE Considerations**	**PHYSICIANS PHONE #**
☐ **Cardiovascular**	☐ **Seizure Disorder**	☐ **Skeletal Limitations**	☐ **Developmental Disability**	
☐ **Other:**				

PLEASE LIST CURRENT MEDICATIONS, IF ANY:

***Important:** If medication is to be taken during school hours, a signed* **Authorization for Administration of Oral Medication Taken at School** *must be on file.*
All prescriptions and Over-The-Counter medications are to be kept in the school office.

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*) *Last Name* *First Name*	RELATIONSHIP TO CHILD	PHONE # (include area code) ☐ **Home** ☐**Work** ☐**Cell**	PHONE #2 (include area code) ☐ **Home** ☐**Work** ☐**Cell**
PRIMARY CONTACT ADDRESS *Street*	*City*	*State*	*Zip*
SECONDARY CONTACT *(other than parent/guardian)* *Last Name* *First Name*	RELATIONSHIP TO CHILD	PHONE # (include area code) ☐ **Home** ☐**Work** ☐**Cell**	PHONE #2 (include area code) ☐ **Home** ☐**Work** ☐**Cell**
PRIMARY CONTACT ADDRESS *Street*	*City*	*State*	*Zip*

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:* _______________________

Columbia School District
Student Health History
To be completed by parent/guardian

Name of Student: ______________________________ Birthdate: _____________ Grade: _______ Sex: ☐ Male ☐ Female

☐ No ☐Yes Glasses/Contacts, Date of last eye evaluation: ______________________________

☐ No ☐Yes Hearing aids, Date of last hearing exam: ______________________________

Daily Medications
State law require written permission from a Health Care Provider and parent before any medication (prescription or over-the-counter) can be given at school. A form is available from the school office

☐ No ☐Yes Medication needed at school? **List:** ______________________________

☐ No ☐Yes Medication needed at home? **List:** ______________________________

Life Threatening Medical Conditions
Washington state law mandates that students with life-threatening health conditions, where the condition would "put the child in danger of death during the school day", have medication/treatment orders and a nursing plan in place at school before your child can attend school. Forms are available from the school office.

Life Threatening Conditions (WILL require Health Care Provider Orders) Please check all that apply:

☐ No ☐Yes Severe allergic reaction to NUTS **List:** ______________________

☐ No ☐Yes Severe allergic reaction to Bee Stings

☐ No ☐Yes Other Severe allergies – affecting school Specify: ______________________

☐ No ☐Yes Severe Asthma: **Regularly takes** medication for asthmatic condition or hospitalized within last 5 years for asthmatic condition

☐ No ☐Yes Diabetes

☐ No ☐Yes Other: ______________________________

Potentially Life Threatening Conditions (May require Health Care Provider orders) Please check all that ap and explain:

☐ No ☐Yes Asthma: takes medication only when needed

☐ No ☐Yes Seizure Disorder: Type of seizures and date of last seizure: ______________________

☐ No ☐Yes Heart Condition: ______________________________

☐ No ☐Yes Behavioral/Emotional Concerns: ______________________________

☐ No ☐Yes Orthopedic Condition: ______________________________

☐ No ☐Yes Other Health Concerns: ______________________________

Does child have any other condition that will affect classroom performance or P.E. activities?

☐ No ☐Yes If yes, explain: ______________________________

This information is considered confidential. It will be shared with school staff as needed during the time your child is enrolled in Columbia School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.

______________________________ ______________________________

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.)

- ☐ NOT HISPANIC/LATINO
- ☐ CUBAN
- ☐ DOMINICAN
- ☐ SPANIARD
- ☐ PUERTO RICAN
- ☐ MEXICAN/ MEXICAN AMERICAN/ CHICANO
- ☐ CENTRAL AMERICAN
- ☐ SOUTH AMERICAN
- ☐ LATIN AMERICAN
- ☐ OTHER HISPANIC/LATINO

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

- ☐ AFRICAN AMERICAN/ BLACK

- ☐ WHITE

- ☐ ASIAN INDIAN
- ☐ CAMBODIAN
- ☐ CHINESE
- ☐ FILIPINO
- ☐ HMONG
- ☐ INDONESIAN
- ☐ JAPANESE
- ☐ KOREAN
- ☐ LAOTIAN
- ☐ MALAYSIAN
- ☐ PAKISTANI
- ☐ SINGAPOREAN
- ☐ TAIWANESE
- ☐ THAI
- ☐ VIETNAMESE
- ☐ OTHER ASIAN

- ☐ NATIVE HAWAIIAN
- ☐ FIJIAN
- ☐ GUAMANIAN or CHAMORRO
- ☐ MARIANA ISLANDER
- ☐ MELANESIAN
- ☐ MICRONESIAN
- ☐ SAMOAN
- ☐ TONGAN
- ☐ OTHER PACIFIC ISLANDER

- ☐ ALASKA NATIVE
- ☐ CHEHALIS
- ☐ COLVILLE
- ☐ COWLITZ
- ☐ HOH
- ☐ JAMESTOWN
- ☐ KALISPEL
- ☐ LOWER ELWHA
- ☐ LUMMI
- ☐ MAKAH
- ☐ MUCKLESHOOT
- ☐ NISQUALLY
- ☐ NOOKSACK
- ☐ PORT GAMBLE KLALLAM
- ☐ PUYALLUP
- ☐ QUILEUTE
- ☐ QUINAULT
- ☐ SAMISH
- ☐ SAUK-SUIATTLE
- ☐ SHOALWATER
- ☐ SKOKOMISH
- ☐ SNOQUALMIE
- ☐ SPOKANE
- ☐ SQUAXIN ISLAND
- ☐ STILLAGUAMISH
- ☐ SUQUAMISH
- ☐ SWINOMISH
- ☐ TULALIP
- ☐ YAKAMA
- ☐ OTHER WASHINGTON INDIAN
- ☐ 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 YOUR CHILD use the most at home?***	____________________
4. What language(s) do parent/guardians 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 – 12th 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? ❑ Yes ❑ 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:**

Symbols below: ◆ Required for School and Child Care/Preschool
● Required for Child Care/Preschool Only

Parent/Guardian Name (please print):

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

Parent/Guardian Signature Required **Date**

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
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.

- ❑ Diphtheria
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hib
- ❑ Measles
- ❑ Mumps
- ❑ Polio
- ❑ Rubella
- ❑ Tetanus
- ❑ Varicella
- ❑ Other: _______________ _______________

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):

#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 ▶

EXAMPLE

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.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
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)	Menactra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqta	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrcl)	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 (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	*Haemophilus influenzae* type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

Washington State Department of Health

DOH 348-106 June 2011

Certificate of Exemption

For School, Child Care and Preschool Immunization Requirements[1]

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):

Parent/Guardian, please choose the exemption(s) that apply to your child below.

☐ **Temporary Medical Exemption**
☐ **Permanent Medical Exemption**

________________ Until ________________
Vaccine(s) Date (or Permanent)

Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X X
Signature of Licensed Health Care Provider Date

☐ **Personal/Philosophical Exemption (see Box 1)**
☐ **Religious Exemption (see Box 1)**
☐ **Religious Membership Exemption (see Box 2)**

I do not want my child to get the following vaccine(s):

☐ Diphtheria ☐ Hepatitis B ☐ Hib
☐ Measles ☐ Mumps ☐ Pertussis (whooping cough)
☐ Pneumococcal ☐ Polio ☐ Rubella
☐ Tetanus ☐ Varicella (chickenpox)

☐ Other (indicate):

Box 1

Provider Statement[2]: "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

Box 2

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

Box 3

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

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.