



Certificate of Immunization Status (CIS)

Reviewed by: _____ Date: _____
 Signed COE on File? Yes No

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

Child's Last Name: _____ First Name: _____ Middle Initial: _____ Birthdate (MM/DD/YYYY): _____

I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.

Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.

Parent/Guardian Signature _____ Date _____ Parent/Guardian Signature Required if Starting in Conditional Status _____ Date _____

▲ Required for School ● Required Child Care/Preschool	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
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Required Vaccines for School or Child Care Entry

● ▲ DTaP (Diphtheria, Tetanus, Pertussis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
● ▲ DT or Td (Tetanus, Diphtheria)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
● ▲ Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
● Hib (<i>Haemophilus influenzae type b</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
● ▲ IPV (Polio) (any combination of IPV/OPV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
● ▲ OPV (Polio)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
● ▲ MMR (Measles, Mumps, Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
● PCV/PSPV (Pneumococcal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
● ▲ Varicella (Chickenpox)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> History of disease verified by IIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Recommended Vaccines (Not Required for School or Child Care Entry)

Flu (Influenza)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HPV (Human Papillomavirus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MCV/MPSV (Meningococcal Disease types A, C, W, Y)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MenB (Meningococcal Disease type B)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Documentation of Disease Immunity (Health care provider use only)

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:
 A verified history of varicella (chickenpox) disease.
 Laboratory evidence of immunity (titer) to disease(s) marked below.

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

Polio (all 3 serotypes must show immunity)

Printed Name: _____
 Licensed Health Care Provider Signature Date: _____

I certify that the information provided on this form is correct and verifiable.
 Health Care Provider or School Official Name: _____ Signature: _____ Date: _____
 If verified by school or child care staff the medical immunization records must be attached to this document.