



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):** _____

Parent/Guardian Signature _____ **Date** _____

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

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.

	Date	Date	Date	Date	Date	Date
	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY

Required Vaccines for School or Child Care Entry						
	Date	Date	Date	Date	Date	Date
	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
<ul style="list-style-type: none"> ▲ Required for School ● Required Child Care/Preschool 						
▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)						
▲ DT or Td (Tetanus, Diphtheria)						
▲ Hepatitis B						
● Hib (<i>Haemophilus influenzae</i> type b)						
▲ IPV (Polio) (any combination of IPV/OPV)						
▲ OPV (Polio)						
▲ MMR (Measles, Mumps, Rubella)						
● PCV/PPSV (Pneumococcal)						
<ul style="list-style-type: none"> ▲ Varicella (Chickenpox) <input type="checkbox"/> History of disease verified by IIS 						

Recommended Vaccines (Not Required for School or Child Care Entry)						
	Date	Date	Date	Date	Date	Date
	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

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

Health Care Provider or School Official Name: _____ Signature: _____
 If verified by school or child care staff the medical immunization records must be attached to this document. Date: _____

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.

Diphtheria Hepatitis A Hepatitis B

Hib Measles Mumps

Rubella Tetanus Varicella

Polio (all 3 serotypes must show immunity)

▲ _____

Licensed Health Care Provider Signature Date

▲ _____

Printed Name