Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Washington State Department of Health

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
C
Symbols

I certify that the information provided on this form is correct and verifiable.
02-20-2015
Parent/guardian Signature Required Date

Vaccine	Dose	Date Month	Day	Year
◆ Hepatitis B (Hep B)				
	1	01	23	2010
	2	03	31	2014
	3	03	31	2014
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
	1	01	23	2010
	2	03	31	2010
	3	04	5	2010
	4	05	15	2011
	5	03	31	2014
◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)				
	1	1	23	2010
	2	03	31	2014
● *Haemophilus influenzae* type b (Hib)				
	1	01	23	2010
	2	03	31	2010
	3	07	15	2010
	4			
● Pneumococcal (PCV, PPSV)				
	1	03	31	2010
	2	07	15	2010
	3	05	10	2011
	4	06	17	2011

Vaccine	Dose	Date Month	Day	Year
◆ Polio (IPV, OPV)				
	1	1	23	2010
	2	03	31	2010
	3	04	5	2010
	4	03	31	2014
Influenza (flu, most recent)				
◆ Measles, Mumps, Rubella (MMR)				
Measles	1	09	02	2010
MMR	2	07	01	2011
MMR		03	15	2012
◆ Varicella (chickenpox) or verify disease 1-4 ▶				
	1	06	28	2011
	2	06	30	2012
Hepatitis A (Hep A)				
	1	07	27	2010
	2	12	13	2010
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	☐ Mumps	☐ Other:
☐ Hepatitis A	☐ Polio	_____
☐ Hepatitis B	☐ Rubella	_____
☐ Hib	☐ Tetanus	
☐ Measles	☐ Varicella	

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