Certificate of Immunization Status (CIS)

DOH 348-013 January 2015

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 Information System.

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
■ Recommended, but not required

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

Parent/Guardian Signature Required **Date**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

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)				
	1			
■ Tetanus, Diphtheria (Td)				
	1			
	2			
● *Haemophilus influenzae* type b (Hib)				
	1			
	2			
	3			
	4			
■ Influenza (flu, most recent)				

Vaccine	Dose	Date		
		Month	Day	Year
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			
	5			
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox)				
	1			
	2			
■ Hepatitis A (Hep A)				
	1			
	2			
■ Human Papillomavirus (HPV) – does not print from the IIS; write dates in by hand				
	1			
	2			
	3			
■ Meningococcal (MCV, MPSV)				
	1			
	2			

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

1) ❑ Chickenpox disease verified by printout from the Immunization Information System (IIS)
Must be marked by printout (not by hand) to be valid.

2) ❑ Chickenpox disease verified by healthcare provider (HCP)
If you choose this box, mark 2A **OR** 2B below.
2A) ❑ Signed note from HCP attached **OR**
2B) ❑ HCP sign here and print name below:

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) **Date**

Printed Name:

3) ❑ Chickenpox disease verified by school staff from the Immunization Information System

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 healthcare provider signature (MD, DO, ND, PA, ARNP) **Date**

Printed Name:

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

#1 To print with information filled in: First, ask if your healthcare provider's office puts vaccination history into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS**, and return it to school or child care. If your provider's office does not use the IIS, 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 had chickenpox (varicella) disease and not the vaccine, **use only one** of these three options to record this on the CIS:

1) ❑ If your child's CIS is printed directly from the IIS (by your healthcare provider or school), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the IIS printout (not by hand).

2) ❑ If your healthcare provider can verify that your child had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your provider, or 2B if your provider signs and dates in the space provided. Be sure your provider's full name is also printed.

3) ❑ If school staff access the IIS and see verification that your child had chickenpox, they will mark box 3.

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your healthcare provider fill in this box. Ask your provider 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**, and return to the school or child care.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	FluLaval	Flu	Ipol	IPV	PedvaxHIB	Hib	Twinrix (Twnrx)	Hep A + Hep B
Adacel	Tdap	FluMist	Flu	Infanrix	DTaP	Pentacel (Pntcl)	DTaP + Hib + IPV	Vaqta	Hep A
Afluria	Flu	Fluvirin	Flu	Kinrix (Knrx)	DTaP + IPV	Pneumovax	PPSV or PPV23	Varivax	Varicella
Boostrix	Tdap	Fluzone	Flu	Menactra	MCV or MCV4	Prevnar	PCV or PCV7 or PCV13		
Cervarix	HPV2	Gardasil	HPV4	MenHibrix (Mnhbrx)	Meningococcal C/Y-HIB-PRP	ProQuad (PrQd)	MMR + Varicella		
Daptacel	DTaP	Havrix	Hep A	Menomune	MPSV or MPSV4	Recombivax HB	Hep B		
Engerix-B	Hep B	Hiberix	Hib	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)		
Fluarix	Flu	HibTITER	Hib	Pediarix (Pdrx)	DTaP + Hep B + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.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 (IIV 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

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

DOH 348-013 January 2015

CHILD'S HEALTH INFORMATION

Date of Child's Last Physical Examination:	Child's Health Care Provider's Name	10 Digit Telephone Number
Street Address	City	Zip Code

Special Health Problems	Allergies, Including Drug Reactions
Regular Medications	Other Pertinent Data

Child's Dentist's Name	10 Digit Telephone Number
Street Address	City Zip Code

CHILD'S MEDICAL INSURANCE COVERAGE

Insurance Company Name	Member/Policy Number
Policy Holder Name	Employer Name
Insurance Company Name	Member/Policy Number
Policy Holder Name	Employer Name

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

I hereby give permission that my child,_____,

may be given emergency treatment by a qualified child care provider at

_____,

Name and/or Address

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

Child Care Agreement

	First	Middle	Last
Child's name:			
Parent or guardian name:	First	Middle	Last
Parent or guardian name:	First	Middle	Last

Days and times my child will receive care:

Check days of care	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
Arrival time							
Departure time							

Fee: $ per: ☐ Hour ☐ Day ☐ Week ☐ Month	Date payment due: Source of payment: ☐ Parent ☐ Other (specify):
Overtime rate: $ per	Late fee: $ per
Other Fees: $ Description:	

I agree to promptly notify the child care provider of any changes of the above information. I understand that I am fully responsible for the terms of this agreement as stipulated.

I have read, understand and agree to comply with the policy and procedures and information for parents given to me by

_____

Name of licensee

Parent or guardian signature Date	Parent or guardian signature Date

I agree to provide child care services according to the above plan. I agree to promptly notify the parents or guardians of any changes to above information.

Licensee signature Date

Street address City State Zip code

Comments

Child Care Registration Form		Date child entered care	Date child left care
Child's name Last First Middle		Name (Nickname) used	Birthdate
Street address		City	Zip code
Child's parent/guardian name	home phone # ( ) -	cell phone# ( ) -	alternative phone # ( ) -
Street address		City	Zip code
Address where you can be reached while child is in care		City	Zip code
Child's parent/guardian name	home phone # ( ) -	cell phone# ( ) -	alternative phone # ( ) -
Street address		City	Zip code
Address where you can be reached while child is in care		City	Zip code

Other than you, who else has permission to pick up your child?

Name	Address	Telephone number
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -

In case of an emergency, I give permission for any of the following individuals to be contacted and my child may be released to any of them.

Parent/Guardian signature: _____

Name	Address	Telephone number
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -

Who does not have permission to pick up your child? If applicable (A copy of supporting court document must be on file)	
Name	Reason

Child's health information		
Date of child's last physical exam:	Child's health care provider	Telephone number ( ) -
Street address	City	Zip code
Special health problems? Yes or no? If yes, specify.	Allergies, including drug reactions Yes or no? If yes, specify.	
Regular medications? Yes or no? If yes, specify.	Other important information Yes or no? If yes, specify.	
Child's dentist's name		Telephone number ( ) -
Street address	City	Zip code

Child's medical insurance coverage	
Insurance company name	Member/policy number
Policy holder name	Employer name
Insurance company name	Member/policy number
Policy holder name	Employer name

Consent to medical care and treatment of minor children

I give permission that my child,_____, may be given first aid/emergency treatment by a the child care licensee and/or qualified staff at:

Name of Licensee_____,

Address of Licensee_____.

Parent/guardian signature	Date	Parent/guardian signature	Date

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.
I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.
I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian signature	Date	Parent/guardian signature	Date

Family Home Child Care
General Permission Authorization

WAC 170-296A-6400 Off-site activities—Parent or guardian permission

(2) For scheduled or unscheduled off-site activities that may occur more than once a month, the licensee must:

(a) Have a signed parent or guardian permission on file for each child; and

(b) Inform parents and guardians about how to contact the licensee when children are on an off-site activity

Child's name First Middle Last	Licensee's Name

Off-site activities that may occur more than once a month:

☐ Walks

☐ Neighborhood Park

☐ Other (specify)

☐ Other (specify)

The children will be transported by motor vehicle: Yes ☐ No ☐	We will be going on this outing using public transportation: Yes ☐ No ☐

Notes:

I give permission for my child to participate in the off-site activities checked above:

Child's name:

Parent or guardian signature	Date

This permission is granted when the licensee follows all the requirements for transporting children. WAC 170-296A-6475

In case of an emergency, I give permission for my child to receive medical treatment. In case of such an emergency, please contact:

Name	Phone Number ( ) -

Parent or guardian signature	Date

Copies to parent or guardian and licensee

LIABILITY RELEASE WITH PARENTAL CONSENT
FOR MEDICAL/EMERGENCY TREATMENT AND TRANSPORTATION

CHILD'S NAME _____ DATE OF BIRTH _____

ADDRESS _____

TEL# _____ CELL1 # _____ CELL 2# _____

The undersigned(s) being the lawful parent(s) and/or guardian(s) of the above child, hereby consent to the participation by the child in all childcare, education and related events and/or activities conducted by Imagine Montessori School and/or Imagine Montessori School staff.

The undersigned hereby further authorize(s) any of the staff, employees, agents and representatives of Imagine Montessori School to provide for, approve and authorize any health care at any hospital, emergency room, doctor's office or other institution, employ any physicians, dentists, nurses or other person whose services may be needed for such health care, review and if necessary disclose the contents of any medical records, execute any consent form required by medical, dental or other health authorities incident to the provision of medical, surgical, or dental care to the child. Health care shall include, but not be limited to the administration of anesthesia, x-ray, examination, and performance of operations, diagnostic and other procedures.

The undersigned(s) hereby further authorize(s) emergency transportation by either Imagine Montessori School personnel or if necessary by ambulance or other emergency vehicle.

If there is no medical emergency, the Imagine Montessori School staff will first use reasonable efforts to contact the parent(s) and /or guardian(s) before administering or authorizing any treatment.

Notwithstanding other provisions in this consent form, Imagine Montessori School shall not have the authority to withhold or withdraw life-sustaining procedures for the child.

Imagine Montessori School is well child-proofed and the children are consistently well supervised. However, accidents do happen. The undersigned(s) assume(s) all risk of injury or harm to the child associated with participation in Imagine Montessori School and agree(s) to release, indemnify, defend and forever discharge Imagine Montessori School and its staff, employees, and agents of and from all liability, claims, demands, damages, costs, expenses, actions and causes of action in respect of death, injury, loss or damage to the child, or by the child, howsoever caused, arising or to arise by reason of or during the child's participation in Imagine Montessori School.

_____ _____

Signature of Parent/Guardian Date