

### Acceptable Versions of a Medically Verified Certificate of Immunization Status (CIS)

A CIS printed from the [WA Immunization Information System \(IIS\)](#)

The IIS only accepts medically verified vaccination dates into the system. Therefore, any CIS printed directly from the IIS is medically verified. No additional parent or health care provider signature is needed to verify the accuracy of the information.

There are two versions of a CIS that prints from the IIS. Both are acceptable and neither require a parent or health care provider signature verifying the information is accurate.

#### Validated CIS ([Printing Instructions](#))

Child's Last Name:		First Name:	Middle Name:	Birthdate (DD/MM/YYYY):			SHS ID Number	
CAT		LAURIE	(K)	V-DISEASE MMR-IMM1 01/03/2015			1610628	
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.				I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school I must provide the required documentation of immunization within the established deadlines. See information below about conditional status.				
Parent/Guardian Signature		Date		Parent/Guardian Signature Required if Starting in Conditional Status			Date	
<b>COMPLETE</b>								
Assessment of Required Immunizations for <b>GRADE K-6</b> Expiration Date: _____ Validated by the Immunization Information System on 10/01/2020				Conditional Status: Children can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. Students in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to turn in documentation. For multiple vaccinations, conditional status continues in a similar manner until all required vaccines are complete. If documentation is not provided within the conditional period, the student must be excluded from further attendance.				
* Required for Preschool/Child Care Only	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Positive Titer	
<b>Required Vaccines for School or Child Care Entry</b>								
DTaP (Diphtheria, Tetanus, Pertussis)	05/01/2015	07/01/2015	09/01/2015	03/01/2016	03/01/2019			
Tdap (Tetanus, Diphtheria, Pertussis)								
DT or Td (Tetanus, Diphtheria)								
Hepatitis B	03/01/2015	05/01/2015	07/01/2015	09/01/2015				
Hib ( <i>Haemophilus influenzae type b</i> )*								
IPV (Polio) (any combination of IPV/OPV)	05/01/2015	07/01/2015	09/01/2015	03/01/2019				
OPV (Polio)								
MMR (Measles, Mumps, Rubella)	03/01/2016						IMMUNE	
PCV/PPSV (Pneumococcal)*	11/15/2017							
Varicella (Chickenpox) <input checked="" type="checkbox"/> History of disease verified by IIS								
<b>Recommended Vaccines (Not Required for School or Child Care Entry)</b>								
Flu (Influenza)	10/17/2018	11/27/2019						
Hepatitis A								
HPV (Human Papillomavirus)								
MCV/MPSV (Meningococcal Disease types A, C, W, Y)								
MenB (Meningococcal Disease type B)								
Rotavirus								

The validated CIS only prints valid vaccination dates from the IIS. It does not print invalid doses because they are not used to determine series completion. Doses may be invalid if given outside of the national recommended schedule, were expired or weren't stored correctly.

The validated CIS lists the child's immunization status as Complete, Not Complete or Conditional. A school age (preschool-12<sup>th</sup> grade) child's immunization status is assessed by their grade level. Children in child care have their immunization status assessed by their age. For example, the certificate shown above is validated for Grades K-6, as highlighted in **yellow**. For an explanation about the terms, see the [Frequently Asked Questions about the Certificate of Immunization Status](#).

The validated CIS can show laboratory evidence of immunity entered into the IIS by a health care provider, as highlighted in **green**. If a positive titer date prints on the CIS, no other provider verification is needed. For example, the certificate above says COMPLETE even though there is only one dose of MMR vaccine.

The validated CIS can show history of chickenpox disease from the IIS, as highlighted in **blue**. If disease history shows on the CIS, no other provider verification is needed. For example, the certificate above says COMPLETE even though there are no doses of varicella vaccine.

For more information about the validated CIS and the second page Action Report, see: [Validated CIS Quick Reference Guide \(PDF\)](#)

**A CIS printed from MyIR**

MyIR allows a parent to access their family's immunization records securely online for vaccinations recorded in the IIS. Parents can register to use MyIR to view their own or their children's immunization records and print a CIS. Like the validated CIS, the MyIR CIS prints the immunization dates from the IIS. There are two versions: the Validated CIS from MyIRMobile.com and the older version that was in MyIR.net.

**MyIRMobile.com**

The MyIR Mobile CIS is very similar to the validated CIS from the WAIS. It also lists the child's immunization status as Complete, Conditional or Not Complete, based on the grade of a child in school or their age in child care, as highlighted in **yellow**. Unlike the validated CIS from the IIS it does not include immunity by antibody titer. Depending on how it was entered in the WAIS it may not reflect history of chickenpox disease, as highlighted in **blue**.

Child's Last Name:		First Name:		Middle Name:		Birthdate (MM/DD/YYYY):		SIS ID Number			
GRAFF		A CIRCE CAT		Katherine		02/01/2010		N/A printed from MyIR			
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.					I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school I must provide the required documentation of immunization within the established deadlines. See information below about conditional status.						
Parent/Guardian Signature				Date		Parent/Guardian Signature Required if Starting in Conditional Status				Date	
<b>COMPLETE</b>											
Assessment of Required Immunizations:				SY 2023-2024 Grade 7-10				Conditional Status: Children can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. Students in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to turn in documentation. For multiple vaccinations, conditional status continues in a similar manner until all required vaccines are complete. If documentation is not provided within the conditional period, the student must be excluded from further attendance.			
Expiration Date:											
Validated by MyIR from the Immunization Information System on:				08/02/2023							
* Required for Preschool/Child Care Only											
<b>Required Vaccines for School or Child Care Entry</b>											
DTaP (Diphtheria, Tetanus, Pertussis)	04/01/10	06/01/10	08/01/10	08/01/11	02/01/14						
Tdap (Tetanus, Diphtheria, Pertussis)	02/01/21										
DT or Td (Tetanus, Diphtheria)											
Hepatitis B	02/01/10	04/01/10	08/01/10								
Hib (Haemophilus influenzae type b)*											
IPV (Polio)	04/01/10	06/01/10	08/01/10	02/01/14							
OPV (Polio)											
MMR (Measles, Mumps, Rubella)	02/01/19	02/01/23									
PCV/PPSV (Pneumococcal)*											
Varicella (Chickenpox)	<input checked="" type="checkbox"/> History of disease verified by IIS		02/01/11	02/01/14							
<b>Recommended Vaccines (Not Required for School or Child Care Entry)</b>											
COVID-19	11/30/21	12/21/21	06/22/22	09/18/22							
Flu (Influenza)	10/01/22										
Hepatitis A	02/01/16										
HPV (Human Papillomavirus)											
MCV/MPSV (Meningococcal Disease types A, C, W, Y)											
MenB (Meningococcal Disease type B)											
Rotavirus											

**A CIS printed from MyIR.net**

This is the older version of the MyIR.net CIS. Copies of this CIS turned in before 2024 are still acceptable and considered medically verified because the vaccination dates came from the IIS. A CIS from MyIR will print 'reviewed by MyIR' and the date the CIS was generated in the Office Use Only box, as seen highlighted in yellow.

**Certificate of Immunization Status (CIS)**  
DOH 348-013 January 2015

**Office Use Only:**  
Reviewed by: MyIR Date: 03/24/2020  
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: Complete First Name: Five Middle Initial: Birthdate (mm/dd/yyyy): 07/16/2009 Sex: M

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.

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.   
 Katherine Graff 03/24/2020   
 Parent/Guardian Signature Required Date

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Hepatitis B (Hep B)</b>				
Hep B	1	07	17	2009
Hep B	2	09	19	2009
Hep B	3	01	22	2010
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
<b>■ Rotavirus (RV1, RV5)</b>				
	1			
	2			
	3			
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>				
DTaP	1	09	19	2009
DTaP	2	11	23	2009
DTaP	3	01	22	2010
DTaP	4	01	19	2011
DTaP	5	08	13	2014
<b>◆ Tetanus, Diphtheria, Pertussis (Tdap)</b>				
	1			
<b>■ Tetanus, Diphtheria (Td)</b>				
	1			
	2			
<b>● Haemophilus influenzae type b (Hib)</b>				
	1			
	2			
	3			
	4			
<b>■ Influenza (flu, most recent)</b>				

Vaccine	Dose	Date		
		Month	Day	Year
<b>● Pneumococcal (PCV, PPSV)</b>				
	1			
	2			
	3			
	4			
	5			
<b>◆ Polio (IPV, OPV)</b>				
IPV	1	09	19	2009
IPV	2	11	23	2009
IPV	3	01	22	2010
IPV	4	08	13	2014
<b>◆ Measles, Mumps, Rubella (MMR)</b>				
MMR	1	07	30	2013
MMR	2	08	13	2014
<b>◆ Varicella (chickenpox)</b>				
	1			
	2			
<b>■ Hepatitis A (Hep A)</b>				
	1			
	2			
<b>■ Human Papillomavirus (HPV) – does not print from the IIS; write dates in by hand</b>				
	1			
	2			
	3			
<b>■ Meningococcal (MCV, MPSV)</b>				
	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 Date (MD, DO, ND, PA, ARNP)

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  Mumps  Other: \_\_\_\_\_   
 Hepatitis A  Polio \_\_\_\_\_   
 Hepatitis B  Rubella \_\_\_\_\_   
 Hib  Tetanus \_\_\_\_\_   
 Measles  Varicella \_\_\_\_\_

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


Printed Name:

The MyIR CIS prints all vaccination dates from the IIS, including valid and invalid dates. The dates on the MyIR CIS should be reviewed to make sure they meet the minimum ages and intervals for the vaccine series as described in the [Immunization Requirements](#) section of the School and Child Care Immunization page [www.doh.wa.gov/SCCI](http://www.doh.wa.gov/SCCI).

The MyIR CIS checks box 1 if a history of chickenpox disease was entered into the IIS, as highlighted in blue. If chickenpox disease history prints on the CIS, then no other health care provider verification is needed. The MyIR CIS has a section where a health care provider can document a child's history of chicken pox disease or evidence of immunity by hand.

Hardcopy [Certificate of Immunization Status \(CIS\)](#) completed by hand

Parents may fill out a hardcopy CIS with their child’s vaccination dates. Children coming from out of state are most likely to have this version, since the IIS may not have any or all of their records.

		<h2 style="margin: 0;">Certificate of Immunization Status (CIS)</h2>		Reviewed by: _____ Date: _____ Signed COE on File? <input type="checkbox"/> Yes <input type="checkbox"/> 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.																																																																																																																																														
X _____ Parent/Guardian Signature			X _____ Parent/Guardian Signature Required if Starting in Conditional Status																																																																																																																																														
Date: _____			Date: _____																																																																																																																																														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 10%;">Date MM/DD/YY</th> <th style="width: 10%;">Date MM/DD/YY</th> <th style="width: 10%;">Date MM/DD/YY</th> <th style="width: 10%;">Date MM/DD/YY</th> <th style="width: 10%;">Date MM/DD/YY</th> <th style="width: 10%;">Date MM/DD/YY</th> </tr> </thead> <tbody> <tr> <td colspan="7" style="text-align: center;"><b>Required Vaccines for School or Child Care Entry</b></td> </tr> <tr> <td>▲ DTaP (Diphtheria, Tetanus, Pertussis)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>▲ DT or Td (Tetanus, Diphtheria)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>▲ Hepatitis B</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>• Hib (<i>Haemophilus influenzae type b</i>)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>▲ IPV (Polio) (any combination of IPV/OPV)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>▲ OPV (Polio)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>▲ MMR (Measles, Mumps, Rubella)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>• PCV/PPSV (Pneumococcal)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>▲ Varicella (Chickenpox)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td><input type="checkbox"/> History of disease verified by IIS</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td colspan="7" style="text-align: center;"><b>Recommended Vaccines (Not Required for School or Child Care Entry)</b></td> </tr> <tr> <td>Flu (Influenza)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Hepatitis A</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>HPV (Human Papillomavirus)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>MCV/MPSV (Meningococcal Disease types A, C, W, Y)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>MenB (Meningococcal Disease type B)</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Rotavirus</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>							Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	<b>Required Vaccines for School or Child Care Entry</b>							▲ DTaP (Diphtheria, Tetanus, Pertussis)							▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)							▲ DT or Td (Tetanus, Diphtheria)							▲ Hepatitis B							• Hib ( <i>Haemophilus influenzae type b</i> )							▲ IPV (Polio) (any combination of IPV/OPV)							▲ OPV (Polio)							▲ MMR (Measles, Mumps, Rubella)							• PCV/PPSV (Pneumococcal)							▲ Varicella (Chickenpox)							<input type="checkbox"/> History of disease verified by IIS							<b>Recommended Vaccines (Not Required for School or Child Care Entry)</b>							Flu (Influenza)							Hepatitis A							HPV (Human Papillomavirus)							MCV/MPSV (Meningococcal Disease types A, C, W, Y)							MenB (Meningococcal Disease type B)							Rotavirus						
	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY																																																																																																																																											
<b>Required Vaccines for School or Child Care Entry</b>																																																																																																																																																	
▲ DTaP (Diphtheria, Tetanus, Pertussis)																																																																																																																																																	
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)																																																																																																																																																	
▲ DT or Td (Tetanus, Diphtheria)																																																																																																																																																	
▲ Hepatitis B																																																																																																																																																	
• Hib ( <i>Haemophilus influenzae type b</i> )																																																																																																																																																	
▲ IPV (Polio) (any combination of IPV/OPV)																																																																																																																																																	
▲ OPV (Polio)																																																																																																																																																	
▲ MMR (Measles, Mumps, Rubella)																																																																																																																																																	
• PCV/PPSV (Pneumococcal)																																																																																																																																																	
▲ Varicella (Chickenpox)																																																																																																																																																	
<input type="checkbox"/> History of disease verified by IIS																																																																																																																																																	
<b>Recommended Vaccines (Not Required for School or Child Care Entry)</b>																																																																																																																																																	
Flu (Influenza)																																																																																																																																																	
Hepatitis A																																																																																																																																																	
HPV (Human Papillomavirus)																																																																																																																																																	
MCV/MPSV (Meningococcal Disease types A, C, W, Y)																																																																																																																																																	
MenB (Meningococcal Disease type B)																																																																																																																																																	
Rotavirus																																																																																																																																																	
<b>Documentation of Disease Immunity (Health care provider use only)</b> 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: <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> A verified history of varicella (chickenpox) disease.</li> <li><input checked="" type="checkbox"/> Laboratory evidence of immunity (titer) to disease(s) marked below.</li> </ul> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Diphtheria</td> <td><input type="checkbox"/> Hepatitis A</td> <td><input type="checkbox"/> Hepatitis B</td> </tr> <tr> <td><input type="checkbox"/> Hib</td> <td><input type="checkbox"/> Measles</td> <td><input type="checkbox"/> Mumps</td> </tr> <tr> <td><input type="checkbox"/> Rubella</td> <td><input type="checkbox"/> Tetanus</td> <td><input type="checkbox"/> Varicella</td> </tr> </table> Polio (all 3 serotypes must show immunity)						<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																																																																																																																																			
<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																																																																																																																																															
_____ Licensed Health Care Provider Signature    Date: _____																																																																																																																																																	
_____ Printed Name																																																																																																																																																	
I certify that the information provided on this form is correct and verifiable.		Health Care Provider or School Official Name: _____ If verified by school or child care staff the medical immunization records must be attached to this document.		Signature: _____ Date: _____																																																																																																																																													

Because this hardcopy CIS does not use records from the IIS, it must be medically validated. This is done by a signature certifying that the information is accurate at the bottom of the page highlighted in **yellow**. The signature can be from:

- A health care provider who is a person licensed, certified or registered in a profession listed in RCW [18.130.040\(2\)](#), if administering vaccinations is within the profession's scope of practice. If the form is signed by a health care provider, no medical immunization records need to be attached to the CIS.

**OR**

- A school nurse, administrator, child care health consultant or their designee. Before signing, they must determine the information on the CIS is accurate after comparing it with the attached medical vaccination records. Please note that CIS forms not signed by a health care provider must have medical vaccination records attached before they can be turned in to the school or child care facility.

The hardcopy CIS also has a section where a health care provider can document history of chickenpox disease, highlighted in **blue**, and evidence of immunity, highlighted in **green**. This

section must be signed by a health care provider to be considered as verification of the disease or of immunity. This signature is highlighted in **yellow**.

**Parent Signatures on the CIS**

CIS forms do not require a parent signature to verify the form’s accuracy. Instead, this is done by a health care provider, school staff, or child care staff.

There are two places where a parent or guardian can sign the CIS.

A parent or guardian signature is required if a child is starting school or child care in conditional immunization status, highlighted in **orange**. The parent or guardian must acknowledge the conditional status rules with their signature if their child will be attending school or child care in conditional status. More information about conditional status can be found on the back of the hardcopy CIS and in the [Conditional Status Attendance](#) section of the of the School and Child Care Immunization page [www.doh.wa.gov/SCCI](http://www.doh.wa.gov/SCCI).

The other signature, highlighted in **purple**, allows school or child care staff to add missing immunization information into the Immunization Information System (IIS) [School Module](#). To do so, staff must have access to the school module. Adding this information into the IIS makes it easier to track immunizations for the school or child care and provides the child with a complete immunization record they can access for their lifetime. This signature block is also on the validated CIS and MyIR CIS. A parent is not required to sign this section.

**Medical Vaccination Records for verifying a Hardcopy CIS**

This section provides examples of some medical immunization records which may be attached to a hardcopy CIS for medical verification. To be acceptable, the record must come from a medical source or include the signature of a health care provider.

Parents or guardians may provide an official lifetime immunization record with a unique healthcare provider stamp. This may also include another form of written healthcare provider documentation, such as a provider signature or initials.

Hepatitis B (Hep B)		
Dose #	Date Given	Physician/Clinic
1	1/25/00	Dr. Carter's clinic
2	4/10/00	Dr. Carter's clinic
3	10/12/00	Dr. Carter's clinic
Diphtheria, Tetanus, Pertussis (DTaP)		
Dose #	Date Given	Physician/Clinic
1	5/11/00	Dr. Carter's clinic
2	10/12/00	Dr. Carter's clinic
3	10/30/03	Dr. Carter's clinic
4	3/3/05	Dr. Hechinks clinic
5	/ /	
Tetanus diphtheria (Td)	/ /	
Booster Dose Every Ten Years	/ /	



Haemophilus influenzae type b (Hib)			
Dose #	Date Given	Physician/Clinic	
1	5/11/00	Dr. Carter's clinic	
2	10/12/00	Dr. Carter's clinic	
3	10/30/03	Dr. Carter's clinic	
4	/ /		
Polio			
Dose #	IPV	OPV	Date Given
1	✓		4/10/00
2	✓		10/12/00
3	✓		10/30/03
4	✓		3/3/05
			/ /
			/ /
Pneumococcal Conjugate (PCV)			
Dose #	Date Given	Physician/Clinic	
1	8/2/01	Dr. Carter's clinic	
2	/ /		
3	/ /		
4	/ /		

Measles, Mumps, Rubella (MMR)			
Type of Vaccine	Dose #	Date Given	Physician/Clinic
MMR	1	8/2/01	Dr. Carter's clinic
MMR	2	3/3/05	MARK A. Hechink
MMR	/ /		
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella (Var)			
Dose #	Date Given	Physician/Clinic	
1	8/2/01	Dr. Carter's clinic	
	/ /		
Hepatitis A (Hep A)			
Dose #	Date Given	Physician/Clinic	
1	/ /		
2	/ /		
Allergies/Vaccine Reactions:			



Parents or guardians may provide an official lifetime immunization record from another country with a unique healthcare provider stamp or provider signature. Official immigration records are also acceptable.

CADA VEZ QUE LLEVE A SU HIJA O HIJO ADOLESCENTE A LA UNIDAD MÉDICA, SOLICITE AL PERSONAL MÉDICO O DE ENFERMERÍA, QUE:

- Revise su Cartilla Nacional de Salud
- Vigile su peso y estatura
- Le realice las actividades de protección específica, principalmente la aplicación de las vacunas que correspondan
- Le informe de las acciones de prevención de enfermedades y de las pruebas de detección de afecciones de salud
- Registre su próxima cita
- Le oriente y capacite sobre los cuidados para conservar o recuperar la salud de su hijo o hija en forma individual o colectiva
- Anote en su Cartilla la fecha de las acciones que le practican

VIGILE QUE SE REALICE A SU HIJA O HIJO ADOLESCENTE TODAS LAS ACCIONES CONTENIDAS EN ESTA CARTILLA. SU PARTICIPACIÓN ES ESENCIAL PARA MANEJAR SU SALUD

IDENTIFICACIÓN: DPO, SANCIONADO Y/O:

APELLIDOS Y NOMBRE: [REDACTED]

APLICACIÓN / MATRÍCULA / RESIDENTE: [REDACTED]

UNIDAD MÉDICA: Hospital Comunitario Alameda

CONSULTORIO No: 2 H3

DATOS GENERALES: EDAD: [REDACTED] SEXO: [REDACTED]

DOMICILIO: Calle y número: [REDACTED] COLONIA / LOCALIDAD: [REDACTED] MUNICIPIO / DELEGACIÓN: [REDACTED]

3699a C.A. Cuautepec INGRESO FEDERATIVO

LUGAR Y FECHA DE NACIMIENTO: [REDACTED] LOCALIDAD / MUNICIPIO O DELEGACIÓN: [REDACTED] ESTADOS UNIDOS MEXICANOS: 11/01/2001 DÍA MES AÑO

ADMINISTRACIÓN	DESARROLLO, SOBREVIVENCIA Y BIENESTAR	PARA TODOS LOS NIÑOS	DESARROLLO PSICOMOTOR
...	...	...	...

CONTRASTAR	ANÁLISIS	REVISIÓN DEL ESTADO DE SALUD	REVISIÓN DEL ESTADO DE SALUD
...	...	...	...

INFLUENZA ESTACIONAL: [REDACTED]

INFLUENZA: [REDACTED] ÚNICA: [REDACTED] CALIFICACIÓN: [REDACTED]

INFLUENZA ESTACIONAL: [REDACTED]

INFLUENZA: [REDACTED] ÚNICA: [REDACTED] CALIFICACIÓN: [REDACTED]



Parents or guardians may provide an immunization record printed from a healthcare provider, clinic or hospital's Electronic Health Record.

**ROCKWOOD**  
Rockwood Clinic- Medical Records  
400 East Fifth Avenue PO Box 3649 Spokane, WA 99220-3649  
509-342-3950

October 30, 2014  
Page 1

Patient Information  
For: [REDACTED] MRN: 002124181 DOB: 01/18/2007

CONFIDENTIAL - Do not re-release without proper authorization

\*Immunization Record-2011

Immunization Record for: [REDACTED]

Vaccine	1	2	3	4	5	6
HepB	01/18/2007	03/16/2007	05/24/2007	07/19/2007		
Hepatitis B	03/15/2007	05/24/2007	07/19/2007	05/06/2008	02/02/2011	
DTP, Tetanus, Pertussis	03/15/2007	05/24/2007	07/19/2007	04/14/2010		XXXXXXXXXX
MM2, Mumps, Rubella	03/15/2007	05/24/2007	07/19/2007	02/02/2011		
Inactivated Poliovirus	05/06/2008	02/02/2011		XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
MM2, Mumps, Rubella	#1 given 05/06/2008	#2 given 02/02/2011		XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Varicella	03/15/2007	05/24/2007	07/19/2007	05/06/2008		
Pneumococcal				XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Hep A						
Hepatitis A						
Tetanus Booster	Flu Shot Date of Last Flu Vac: 11/11/2009	Last Two (2) Documented Flu Vacs: Flu-Historical (11/11/2009)	H1N1 #1 Date of Last: H1N1 #2 Date of Last:	Pneumovax Date of Last:	Meningococcal Vaccine Given: Meningococcal #2	
Tdap Given: Tdap may be due						
HPV	Vaccine/ Date of Last:	Vaccine/ Date of Last:	Vaccine/ Date of Last:	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Rotavirus	Vaccine/ Date of Last:	Vaccine/ Date of Last:	Vaccine/ Date of Last:	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Zostavax	Vaccine/ Date of Last:	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX



Parents or guardians may provide a written immunization record from a healthcare provider or clinic

Vaccine Administration Record For Children and Youth

Patient Name: \_\_\_\_\_ Birthdate: 5/2/2002

Doctors administering any vaccines, print the phone number and appropriate copies of Vaccine Information Statements (VIS) and make sure they understand the risks and benefits of the vaccination. Update this as your personal record or provide a new one whenever you administer a vaccine.

Vaccine	Type of Vaccine (e.g., live, inactivated)	Date given (month/day)	Route	Site given (R, L, RT, LT)	Vaccine	Vaccine Information Statement (VIS) #	Signature/Initials of healthcare provider
Hepatitis B (e.g., Engerix-B, Heplisav-B, Recombinant HBsAg-IPV)			IM				
DTPa, DTaP, DT, Td		10/24/2015	IM	RT	MMR		Michelle Thompson
Meningococcal conjugate (e.g., Menveo, MenQuadri, Menactra)			IM				
Polio (e.g., ProQuad, Imovax Polio, IPV)		10/24/2015	IM	LT	MMR		Michelle Thompson
Pneumococcal conjugate (e.g., Prevnar 13)			IM				
Measles, Mumps, Rubella (MMR)		10/24/2015	IM	RT	MMR		Michelle Thompson
Varicella (e.g., Varivax)			IM				
Hepatitis A (e.g., Havrix, Enduris)		10/24/2015	IM	RT	MMR		Michelle Thompson
Tdap (e.g., Boostrix, Adacel)			IM				
Other							

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Signature: \_\_\_\_\_



Parents or guardians may provide an immunization record printed from the WA IIS or the IIS of another state.

Tennessee Department of Health

CERTIFICATE OF IMMUNIZATION

TEMPORARY NEW 7 GRADE, 13 YEARS OLD, 01/15/2002

Child's Name (Last name, first name, middle): \_\_\_\_\_ Birthdate (mm/dd/yyyy):

Parent/Guardian Name (Last name, first name, middle): \_\_\_\_\_ Phone (please include area code xxx-xxx-xxxx): (154) 789-5623

Address: 1212 OLD HICKORY BLVD, HERMITAGE, TENNESSEE 37076

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Section 1a. Religious Exemption:  Check here if religious exemption to immunization selected by parent/guardian.

1b. Health Examination Documentation (if required):  This child has been examined: MM/DD/YY

1c. Check if needed:  Certified by (Signature/Stamp),  Dental Screening,  Vision Screening

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	Parent (Y)	State (Y)	Other (Y)	Exempt (Y)
Section 2a. Required Vaccines for School or Child Care Attendance (Dates Required)										
Hib (Child Care Only <5 years)										
Pneumococcal (PCV) (Child Care Only <5 years)										
DTPa, DTaP, DT, Td	09/22/2015	10/24/2014								
Poliovirus	10/24/2014	09/22/2015								
Hepatitis B (Check new 11-15 years, 2-dose schedule used)	10/24/2014	09/22/2015								
Hepatitis A (Child Care Effective 7/2015, Kindergarten Effective 7/2014)										
Measles	10/24/2014	09/22/2015								
Mumps	10/24/2014	09/22/2015								
Rubella	10/24/2014	09/22/2015								
Varicella	10/24/2014	09/22/2015								
Tdap Booster (7th Grade Only One)	09/22/2015									
Section 2b. Recommended Vaccines (Documentation Optional)										
Rotavirus										
Influenza										
Meningococcal										
HPV										

Section 3. Provider Assessment (select one, not valid if blank):  A) Temporary Certificate - Expires 12/17/2015 (Expiration date one month after date child up immunization is due.)  
 B) Up to Date for Child Care Entry and <18 Months of Age (Only if requirements incorporate, but up to date for age. Expires at 18 months of age.)  
 C) Complete for Child Care / Pre-School (Fulfills all requirements for child care / Pre-School or pre-K under 5 years of age.)  
 D) Complete K-6th Grade (Fulfills requirements, kindergarten through 6th grade.)  
 E) Complete 7th Grade or Higher (Fulfills requirements, 7th grade or higher.)

Section 4. (Required) Printed or Stamped Name, Address, Phone of Qualified Healthcare Provider (MD, DO, PA, Advanced Practice Nurse or Health Department):  
 818 STREET MEDICAL CENTER  
 218 SIX STREET  
 CLARKSVILLE, TENNESSEE  
 37040  
 931542-0810

Validated by the TN State Immunization Information System on 01/15/2015  
 Certified by (Signature/Stamp) or TennIS Date of Issue  
 Certificate ID: 914881171144292710884



Parents or guardians may provide an immunization record printed from a clinic that is formatted to look like a CIS.

**This document cannot replace the CIS** but it is a medical immunization record that can be attached to a hardcopy CIS.

If you receive one of these documents please let us know at the email [oischools@doh.wa.gov](mailto:oischools@doh.wa.gov) so we can communicate with the provider.

**Certificate of Immunization Status (CIS)**  
DOH 348-013 January 2013

Office Use Only: Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_  
Signed Cert. of Eligibility 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: \_\_\_\_\_

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.  Yes  No

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

Parent/Guardian Signature Required \_\_\_\_\_ Date: \_\_\_\_\_

Vaccine	Dose	Month	Day	Year	Parent/Guardian Signature Required	Date
<b>◆ Hepatitis B (Hep B)</b>						
HepB	1	03	17	12		
HepB	2	04	04	14		
HepB	3	08	12	15		
or Hep B - 2 dose alternate schedule for teens						
	1					
	2					
<b>◆ Rotavirus (RV1, RV5)</b>						
	1					
	2					
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>						
DTaP	1	06	02	09		
DTaP	2	11	02	09		
DTaP	3	06	30	10		
DTaP	4	09	02	10		
DTaP	5	04	04	14		
<b>◆ Tetanus, Diphtheria, Pertussis (Tdap)</b>						
	1					
<b>◆ Tetanus, Diphtheria (Td)</b>						
	1					
<b>◆ Haemophilus influenzae type b (Hib)</b>						
Hib PRP-T	1	05	02	09		
Hib PRP-T	2	07	31	09		
Hib PRP-T	3	11	02	09		
Hib PRP-T	4	06	30	10		
<b>◆ Influenza (Flu, most recent)</b>						
Flu - NOS	1	11	25	09		
Flu - NOS	2	12	31	09		
<b>◆ Pneumococcal (PCV, PPSV)</b>						
PCV13	1	06	02	09		
PCV13	2	10	01	09		
PCV13	3	12	31	09		
PCV13	4	03	31	10		
<b>◆ Polio (IPV, OPV)</b>						
IPV	1	06	02	09		
IPV	2	11	02	09		
IPV	3	04	05	13		
<b>◆ Measles, Mumps, Rubella (MMR)</b>						
MMR	1	10	01	10		
MMR	2	06	02	11		
<b>◆ Varicella (chickenpox)</b>						
VAR	1	04	04	12		
VAR	2	08	12	15		
<b>◆ Hepatitis A (Hep A)</b>						
HepA 1dose	1	07	05	17		
HepA 2dose	2	06	01	18		
<b>◆ Human Papillomavirus (HPV) - does not print from the SIS; write dates in by hand</b>						
	1					
	2					
	3					
<b>◆ Meningococcal (MCV, MPSV)</b>						
	1					
	2					

If the child named on this CIS has chickenpox disease (and not the varicella disease history) must be verified.  
 1)  Chickenpox disease verified by printout from the Immunization Information System (IIS) must be verified by printout from the IIS to be valid.  
 2)  Chickenpox disease verified by healthcare provider (HCP).  
 If you choose the latter, enter SA OR (2) below: SA)  Signed note from HCP attached OR 2B)  HCP sign form and print name below:  
 Licensed healthcare provider signature \_\_\_\_\_ Date (MO, DO, ND, PA, ARNP) \_\_\_\_\_  
 Print Name: \_\_\_\_\_

Documentation of Disease Immunity  
 I certify that the child named on this CIS has laboratory evidence of immunity (titers to disease) as listed. Lab reports for Strep MUST also be attached.  
 Diphtheria  Mumps  Other: \_\_\_\_\_  
 Hepatitis A  Polio  \_\_\_\_\_  
 Hepatitis B  Rubella  \_\_\_\_\_  
 Hib  Tetanus  \_\_\_\_\_  
 Measles  Varicella  \_\_\_\_\_

Licensed healthcare provider signature \_\_\_\_\_ Date (MO, DO, ND, PA, ARNP) 6/22/2019  
 Print Name: \_\_\_\_\_

**Certificate of Immunization Status (CIS)**  
For Kindergarten-12th Grade / Child Care Entry

Office Use Only: Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_  
Signed Cert. of Eligibility on file?  Yes  No

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

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

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.  Yes  No

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

Parent/Guardian Signature Required \_\_\_\_\_ Date: 11/06/19

Parent/Guardian Signature Required \_\_\_\_\_ Date: 11/06/19

Vaccine	Date	Date	Date	Date	Date
	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
<b>Required Vaccines for School or Child Care Entry</b>					
◆ DTaP, DT (Diphtheria, Tetanus, Pertussis)	01/13/03	03/06/03	05/23/03	03/12/04	11/22/06
◆ Tdap (Tetanus, Diphtheria, Pertussis)	04/14/14				
◆ Td (Tetanus, Diphtheria)					
◆ Hepatitis B	01/13/03	03/06/03	07/18/03		
◆ Hib (Haemophilus influenzae type b)	01/13/03	03/06/03	05/23/03	03/12/04	
◆ IPV / OPV (Polio)	02/12/03	04/11/03	02/13/04	11/22/06	
◆ MMR (Measles, Mumps, Rubella)	02/13/04	11/26/07			
◆ PCV / PPSV (Pneumococcal)					
◆ Varicella (Chickenpox)	09/01/04	11/26/07			
<b>Recommended Vaccines (Not Required for School or Child Care Entry)</b>					
Flu (Influenza)	12/17/13	12/16/14	03/15/17	09/27/17	03/12/19
Hepatitis A	04/14/14	04/21/15			
HPV (human Papillomavirus)	03/15/17	09/27/17			
MCV, MPSV (Meningococcal)	04/14/14	09/23/19			
MenB (Meningococcal)					
Rotavirus					

If the child named on this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) IT MUST be verified by a healthcare provider.  
 I certify that the child named on this CIS has:  
 a verified history of Varicella (Chickenpox).  
 laboratory evidence of immunity (titer to disease) as listed. Lab reports for Strep MUST also be attached.

Documentation of Disease Immunity  
 I certify that the child named on this CIS has:  
 Diphtheria  Mumps  Other: \_\_\_\_\_  
 Hepatitis A  Polio  \_\_\_\_\_  
 Hepatitis B  Rubella  \_\_\_\_\_  
 Hib  Tetanus  \_\_\_\_\_  
 Measles  Varicella  \_\_\_\_\_

Licensed healthcare provider signature \_\_\_\_\_ Date (MO, DO, ND, PA, ARNP)  
 Printed Name: \_\_\_\_\_

For more information including a brief video about the CIS and FAQs can be found in the [Certificate of Immunization Status \(CIS\)](#) section of the School and Child Care Immunization page [www.doh.wa.gov/SCCI](http://www.doh.wa.gov/SCCI).

Questions about the CIS can be sent to [OICPSchools@doh.wa.gov](mailto:OICPSchools@doh.wa.gov).