



## STILLWATER ELEMENTARY SCHOOL CHECKLIST for KINDERGARTEN REGISTRATION

### REGISTRATION FORM

Please complete all information requested (3 sheets front and back)

### STUDENT HOUSING QUESTIONNAIRE

Please complete information requested following the instructions

### IMMUNIZATION FORM

Please complete the following information on the **required** Department of Health form:

- 3 Doses of Hepatitis B
- 5 doses Diphtheria, Tetanus, Pertussis (DTP / DT / Td)
- 4 Doses of Oral Polio Vaccine (OPV) or 4 Doses of inactivated Polio Vaccine (IPV)
- 2 Doses of Measles, Mumps, and Rubella (MMR)
- 2 Doses of Varicella

.....*Parents must obtain a Certificate of Exemption from their child's Doctor*

### COPY OF BIRTH CERTIFICATE





# STUDENT REGISTRATION FORM

SW

Has the student ever attended a school in Riverview School District?  Yes  No

<b>FOR OFFICE USE ONLY</b>		Age/Name Verification <input type="checkbox"/>	Proof of Residency <input type="checkbox"/>	Medical Alert <input type="checkbox"/>	Speech/SpED <input type="checkbox"/>	ELL <input type="checkbox"/>
Bus Route _____	Student Number _____	Advisor _____	Entry Date: _____			

## STUDENT INFORMATION ( Please PRINT all information )

STUDENT NAME: Legal Last Name		Legal First Name		Legal Middle Name		Also known as:
BIRTHDATE (Month/Day/Year)	GENDER (M / F)	BIRTHPLACE: City	State	County	Country	
ENTERING GRADE LEVEL		Has the student ever been retained? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, what grade(s):		
Has the student ever been suspended/expelled for: Weapons <input type="checkbox"/> Drugs <input type="checkbox"/> Assault <input type="checkbox"/>				If yes, provide date:		

## STUDENT SERVICES

Has your child ever qualified for or been enrolled in a <b>SPECIAL ED PROGRAM</b> ?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has your child ever qualified for or had:	a <b>504 PLAN</b> ? <input type="checkbox"/>	an <b>IEP</b> (Individual Education Plan)? <input type="checkbox"/>	
Has your child ever participated in:	<b>ELL</b> (English Language Learner) <input type="checkbox"/>	<b>Title/LAP</b> <input type="checkbox"/>	<b>Gifted</b> <input type="checkbox"/> <b>Speech</b> <input type="checkbox"/>
Are there special instructions regarding religious beliefs? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide the information in writing to the school.			

## ETHNICITY & RACE

Is your child of Hispanic or Latino origin? <input type="checkbox"/> Yes (Complete Section 1 & 2) <input type="checkbox"/> No (Complete Section 2) 10	
<b>Section 1: HISPANIC OR LATINO ORIGIN (Check all that apply)</b>	
<input type="checkbox"/> Central American 75	<input type="checkbox"/> Dominican 60
<input type="checkbox"/> Cuban 55	<input type="checkbox"/> Latin American 85
<input type="checkbox"/> Mexican / Mexican American / Chicano 30	<input type="checkbox"/> Puerto Rican 70
<input type="checkbox"/> Spaniard 65	<input type="checkbox"/> South American 80
<input type="checkbox"/> Other Hisp./Latino 90	
<b>Section 2: RACE (Check all that apply)</b>	
<input type="checkbox"/> African American / Black 200	<input type="checkbox"/> White 300
<b>ASIAN</b>	
<input type="checkbox"/> Asian Indian 505	<input type="checkbox"/> Filipino 520
<input type="checkbox"/> Cambodian 507	<input type="checkbox"/> Hmong 525
<input type="checkbox"/> Chinese 510	<input type="checkbox"/> Indonesian 530
<input type="checkbox"/> Japanese 535	<input type="checkbox"/> Malaysian 550
<input type="checkbox"/> Korean 540	<input type="checkbox"/> Pakistani 555
<input type="checkbox"/> Laotian 545	<input type="checkbox"/> Singaporean 560
<input type="checkbox"/> Taiwanese 565	<input type="checkbox"/> Thai 570
<input type="checkbox"/> Vietnamese 575	<input type="checkbox"/> Other Asian 599
<b>NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER</b>	
<input type="checkbox"/> Native Hawaiian 605	<input type="checkbox"/> Guamanian or Chamorro 620
<input type="checkbox"/> Fijian 615	<input type="checkbox"/> Mariana Islander 625
<input type="checkbox"/> Melanesian 630	<input type="checkbox"/> Micronesian 632
<input type="checkbox"/> Samoan 635	<input type="checkbox"/> Tongan 640
<input type="checkbox"/> Other Pacif. Islr. 699	
<b>AMERICAN INDIAN OR ALASKAN NATIVE</b>	
<input type="checkbox"/> Alaska Native 405	<input type="checkbox"/> Lower Elwha 427
<input type="checkbox"/> Chehalis 410	<input type="checkbox"/> Lummi 430
<input type="checkbox"/> Colville 413	<input type="checkbox"/> Makah 433
<input type="checkbox"/> Cowlitz 416	<input type="checkbox"/> Muckleshoot 436
<input type="checkbox"/> Hoh 418	<input type="checkbox"/> Nisqually 439
<input type="checkbox"/> Jamestown 421	<input type="checkbox"/> Nooksack 442
<input type="checkbox"/> Kalispel 424	<input type="checkbox"/> Prt. Gmbl. Klallam 445
<input type="checkbox"/> Puyallup 448	<input type="checkbox"/> Quileute 451
<input type="checkbox"/> Quinault 454	<input type="checkbox"/> Samish 457
<input type="checkbox"/> Sauk-Suiattle 460	<input type="checkbox"/> Shoalwater 463
<input type="checkbox"/> Skokomish 466	<input type="checkbox"/> Snoqualmie 469
<input type="checkbox"/> Tulalip 487	<input type="checkbox"/> Spokane 472
<input type="checkbox"/> Squaxin Island 475	<input type="checkbox"/> Stillaguamish 478
<input type="checkbox"/> Suquamish 481	<input type="checkbox"/> Upper Skagit 488
<input type="checkbox"/> Swinomish 484	<input type="checkbox"/> Yakama 490
<input type="checkbox"/> Other Native Indian/ Alaska Native 499	

The new Federal requirements state that Unknown, Multiracial, and Not Provided are not valid responses to ethnicity or race identification questions. If parents, guardians, or students do not provide ethnicity and race information, districts are responsible for assigning categories based on observation.



**Office of Superintendent of Public Instruction (OSPI)**  
**Home Language Survey**

The Home Language Survey is given to *all* students enrolling in Washington schools.

<b>Student Name:</b> _____		<b>Grade:</b> _____	<b>Date:</b> _____
Parent/Guardian Name _____		Parent/Guardian Signature _____	
<p><b>Right to Translation and Interpretation Services</b>          Indicate your language preference so we can provide an interpreter or translated documents, free of charge, when you need them.</p>	<p>All parents have the right to information about their child's education in a language they understand.</p> <p>1. In what language(s) would your family prefer to communicate with the school?          _____</p>		
<p><b>Eligibility for Language Development Support</b>          Information about the student's language helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.</p>	<p>2. What language did your child learn first?          _____</p> <p>3. What language does your child use the most at home?          _____</p> <p>4. What is the primary language used in the home, regardless of the language spoken by your child?          _____</p> <p>5. Has your child received English language development support in a previous school? Yes ___ No ___ Don't Know ___</p>		
<p><b>Prior Education</b>          Your responses about your child's birth country and previous education:</p> <ul style="list-style-type: none"> <li>• Give us information about the knowledge and skills your child is bringing to school.</li> <li>• May enable the school district to receive additional federal funding to provide support to your child.</li> </ul> <p><i>This form is not used to identify students' immigration status.</i></p>	<p>6. In what country was your child born? _____</p> <p>7. Has your child ever received formal education outside of the United States? (Kindergarten - 12<sup>th</sup> grade) ___ Yes ___ No</p> <p>If yes: Number of months: _____          Language of instruction: _____</p> <p>8. When did your child first attend a school in the United States? (Kindergarten - 12<sup>th</sup> grade)</p> <p>_____</p> <p>Month                  Day                  Year</p>		

Thank you for providing the information needed on the Home Language Survey. Contact your school district if you have further questions about this form or about services available at your child's school.

**Note to district:** This form is available in multiple languages on <http://www.k12.wa.us/MigrantBilingual/HomeLanguage.aspx>. A response that includes a language other than English to question #2 OR question #3 triggers English language proficiency placement testing. Responses to questions #1 or #4 of a language other than English could prompt further conversation with the family to ensure that #2 and #3 were clearly understood. "Formal education" in #7 does not include refugee camps or other unaccredited educational programs for children.

**PHOTO RELEASE AUTHORIZATION:** I give permission for my child's photo to be used for school district publications, newspaper articles, and/or on the district website. Yes  No  If NO -- Allow Yearbook photo? Yes  No

**PREVIOUS SCHOOL**

School Name	District	City/State	Withdrawal Date
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**FAMILY**

<b>PRIMARY HOUSEHOLD</b> (parent/guardian where student resides)			<b>Phone Numbers</b> (w/ area code) Checkmark # to call 1 <sup>st</sup> ↓	
<u>Last Name</u>		<u>First Name</u>	Home	
1.			Work	
E-Mail			Cell	
Relationship to Student: Father <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/>		Interpreter needed? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Grandparent <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/>		Language: _____		
<u>Last Name</u>		<u>First Name</u>	<b>Phone Numbers</b> (w/ area code) Checkmark # to call 1 <sup>st</sup> ↓	
2.			Home	
E-Mail			Work	
Relationship to Student: Father <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/>		Interpreter needed? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Grandparent <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/>		Language: _____		
<u>Residence Address</u>	<u>Street</u>	<u>Apt #</u>	<u>City</u>	<u>State</u> <u>ZIP</u>
<u>Mailing Address</u> (If different)	<u>Street or PO Box</u>	<u>Apt #</u>	<u>City</u>	<u>State</u> <u>ZIP</u>
<b>SECONDARY HOUSEHOLD</b>			<b>Phone Numbers</b> (w/ area code) Checkmark # to call 1 <sup>st</sup> ↓	
<u>Last Name</u>		<u>First Name</u>	Home	
1.			Work	
E-Mail			Cell	
Relationship to Student: Father <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/>		Interpreter needed? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Grandparent <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/>		Language: _____		
<u>Last Name</u>		<u>First Name</u>	<b>Phone Numbers</b> (w/ area code) Checkmark # to call 1 <sup>st</sup> ↓	
2.			Home	
E-Mail			Work	
Relationship to Student: Father <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/>		Interpreter needed? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Grandparent <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/>		Language: _____		
<u>Residence Address</u>	<u>Street</u>	<u>Apt #</u>	<u>City</u>	<u>State</u> <u>ZIP</u>
<u>Mailing Address</u> (If different)	<u>Street or PO Box</u>	<u>Apt #</u>	<u>City</u>	<u>State</u> <u>ZIP</u>
ADDITIONAL MAILINGS REQUESTED Yes <input type="checkbox"/> No <input type="checkbox"/>				

**PLEASE LIST OTHER SIBLINGS ATTENDING RIVERVIEW SCHOOL DISTRICT**

Last Name	First Name	Birth Date	School	Grade



# Student Health Concerns

Student Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_  
 Home Phone: (     ) \_\_\_\_\_ Alternate Phone: (     ) \_\_\_\_\_  
 Parent/Guardian email address: \_\_\_\_\_  
 (Nurses may use email to obtain updates regarding student care plan information.)

In order to provide a safe and healthy environment for your child, this information will be accessible to the following people: principal, nurse, your child's teachers, secretaries, health room assistant, and emergency medical personnel.

## CURRENT HEALTH CONDITIONS - Answer #1 or #2

1. My child has **NO** health concerns at this time. \_\_\_\_\_  
 (Initial and date)
2. Check the ones below that may affect your child at school. Include all health concerns necessary for educational planning and potential needs for emergency care. Explain further details on lines below.
 

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Severe Allergy *	<input type="checkbox"/> Heart problems
<input type="checkbox"/> Asthma *	<input type="checkbox"/> Physical restrictions (that would limit activity)
<input type="checkbox"/> Behavior problems	<input type="checkbox"/> Seizure disorder *
<input type="checkbox"/> Bladder/Bowel concerns	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Diabetes *	<input type="checkbox"/> Other _____

**\*ALERT TO PARENTS:** If your child has a life-threatening health condition (severe allergy, asthma, diabetes, seizures) requiring emergency medication, Washington State Law SHB2834 requires that a medication or treatment order and an Individual Health Plan (IHP) be in place before your child's first day of school each year. Contact your child's School Nurse immediately.

## MEDICATION

Is medication given <b>at home</b> ?	Name of Medication	Used For Treatment Of
Yes <input type="checkbox"/> No <input type="checkbox"/>	1.	
	2.	

Is medication given <b>at school</b> **?	Name of Medication	Used For Treatment Of
Yes <input type="checkbox"/> No <input type="checkbox"/>	1.	
	2.	

\*\* Before medication can be administered or carried at school, a **Medication Authorization form**, available on the district website or in the school office, must be completed by a Licensed Health Care Provider and signed by a parent/guardian.

## IMPORTANT – EMERGENCY TREATMENT

*In case of serious injury, illness or other emergency at school, the district will make every attempt to reach the student's parents or designees. **In the event that the child's parents/guardians or physician cannot be reached**, the building administrator or designee will make a decision as to the most appropriate action to take in the student's best interest. **I authorize school authorities to obtain emergency care for my child.***

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If your child needs health or dental insurance, please contact your school nurse.

**EMERGENCY CONTACTS ( Other than parents/guardians listed in Family section on page 3 )**

When injury, illness or other non-emergency situations occur involving your child, we want to be able to quickly reach families or other responsible adults. **In the event we cannot reach a parent/guardian, please list persons you trust who are available during the day to provide care for your child.** (You are not required to list a total of four contacts.)

<u>Emergency Contact #1</u> <i>Last Name</i> <i>First Name</i>		PHONE #1 Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/>	PHONE #2 Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/>	Relationship
<u>Emergency Contact #2</u> <i>Last Name</i> <i>First Name</i>		PHONE #1 Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/>	PHONE #2 Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/>	Relationship
<u>Emergency Contact #3</u> <i>Last Name</i> <i>First Name</i>		PHONE #1 Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/>	PHONE #2 Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/>	Relationship
<u>Emergency Contact #4</u> <i>Last Name</i> <i>First Name</i>		PHONE #1 Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/>	PHONE #2 Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/>	Relationship
<u>Baby Sitter/Daycare</u>	Name	Address		Phone #

**STUDENT RELEASE AUTHORIZATION:** In the event that the school is unable to contact the parent/guardian, I authorize that my child may be released to the person(s) listed above.    Yes     No

**MILITARY STATUS:** Check the most appropriate box below for parent(s)/guardian(s).

<b>Choose One</b>	<input type="checkbox"/> U.S. Armed Forces active duty (A)	<input type="checkbox"/> More than one member of Armed Forces/National Guard (M)
	<input type="checkbox"/> U.S. Armed Forces reserves (R)	<input type="checkbox"/> No affiliation (N)
	<input type="checkbox"/> National Guard member (G)	

**IS THERE A JOINT CUSTODY OR PARENTING PLAN IN EFFECT?**    Yes     No     (If yes, plan must be on file with the school.)

**IS THERE A RESTRAINING ORDER IN EFFECT?**    Yes     No     (If yes, legal papers must be on file with the school.)

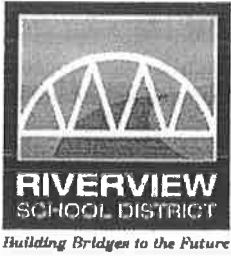
Restraining order is against:    Father     Mother     Other  \_\_\_\_\_

**Will there be an adult/parent present when your student arrives home in the event of early dismissal?**    Yes     No

<b>Choose One</b>	<input type="checkbox"/> I give permission for my student to arrive home <b>WITHOUT</b> adult supervision in the event of a school closure.
	<input type="checkbox"/> My student is to <b>REMAIN AT SCHOOL</b> until a parent/guardian or emergency contact is able to pick her/him up.

**VERIFICATION OF INFORMATION:** The information I have provided in this registration packet is true and accurate as of this date. I certify that I have read and signed where requested.

Legal Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



# Transportation Request

Initial Request

Change Request

Student Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

School \_\_\_\_\_

Grade \_\_\_\_\_

Primary Household Residence Address - both AM and PM

\_\_\_\_\_

OR

AM Pick-Up Address \_\_\_\_\_

Primary Household     Secondary Household     Daycare     Other \_\_\_\_\_

Location Contact Person: \_\_\_\_\_

Location Phone Number(s): \_\_\_\_\_

PM Drop-Off Address \_\_\_\_\_

Primary Household     Secondary Household     Daycare     Other \_\_\_\_\_

Location Contact Person: \_\_\_\_\_

Location Phone Number(s): \_\_\_\_\_

Comments/Instructions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Print Parent/Guardian Name

Parent/Guardian Signature

Date





# Student Housing Questionnaire

**Please use one form per family. Return to school registration office within 14 days of receipt. If you require additional copies, please contact your school.**

NAME OF STUDENT: \_\_\_\_\_

First

Middle

Last

NAME OF SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_

MONTH DAY YEAR

OTHER CHILDREN LIVING IN THE HOME:

NAME: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

NAME: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

NAME: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

The answers to the following questions can help determine the services this student may be eligible to receive under the McKinney-Vento Act 42 U.S.C. 11435.

- 1. Is this student's home address a temporary living arrangement, other than rental? Yes \_\_\_\_\_ No \_\_\_\_\_
- 2. Is this a temporary living arrangement due to a loss of housing or economic hardship? Yes \_\_\_\_\_ No \_\_\_\_\_
- 3. Is this student in a temporary foster care placement or awaiting foster care? Yes \_\_\_\_\_ No \_\_\_\_\_
- 4. As a student, are you living with someone other than your parent or legal guardian? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered YES to **any** of the above questions, please complete the remainder of this form.

If you answered NO to all of the above questions, you may stop here.

Where is this student currently living? (Check One)

- In a motel
- In a Shelter
- "Awaiting" Foster Care
- With more than one family in a house or apartment
- Moving from place to place
- In a location not designed for sleeping accommodations such as a car, park or campsite
- Transitional housing (through community agency)

Address of current Residence: \_\_\_\_\_

(Or)

Name of Motel / Shelter of Current Residence: \_\_\_\_\_

(Or)

Name of "General Area" of Current Residence: \_\_\_\_\_

Phone Number or Contact Number: \_\_\_\_\_ Name of Contact: \_\_\_\_\_

Print name of parent(s)/legal guardian(s): \_\_\_\_\_

(or unaccompanied youth)

Signature of parent/legal guardian: \_\_\_\_\_

(or unaccompanied youth)





# Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

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

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

Parent/Guardian Name (please print): \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Office Use Only: \_\_\_\_\_ Date: \_\_\_\_\_

Signed Cert. of Exemption on file?  Yes  No

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

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

Vaccine	Dose	Date		
		Month	Day	Year
◆ Polio (IPV, OPV)	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox) or verify disease 1-4				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
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	Date
Printed Staff Name	Date	Printed Staff Name	Date	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, Td)				
	1			
	2			
● Haemophilus influenzae type b (Hib)				
	1			
	2			
	3			
	4			
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			

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

**#1 To print with info filled in:** First, ask if your health care provider's office puts vaccination history into the CHLD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHLD Profile and your child's information will fill in automatically. Be sure to review all the information, sign and date the CIS in the upper right hand box, and return it to school or child care. If your provider's office does not use CHLD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

**EXAMPLE**

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

**#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 ►  
**#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 has had chickenpox (varicella) disease and not the vaccine, use only one of these four options to record this on the CIS:

- 1)  If your child's CIS is printed directly from the CHLD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
- 2)  If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
- 3)  If school staff access the CHLD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
- 4)  If your child started kindergarten in the 2008-2009 school year or later, you CANNOT use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: <http://www.doh.wa.gov/cfi/immunize/schools/vaccine.htm>

**#6** Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP 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 in the upper right hand box, and return to school or child care.  
**#8** If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

**Vaccine Trade Names in alphabetical order** (For updated lists, visit <http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf>)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
AchHB	Hib	Engerix-B	Hep B	Ipov	IPV	Penavalente	DTaP + Hep B + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Kinx)	DTaP + IPV	Prennar	PCV or PCV7 or PCV13
Boostrix	Tdap	FluMist	Flu (LAIV)	Menactra	MCV or MCV4	ProQuad (ProQd)	MMR + Varicella
Cervarix	HPV2	Fluavirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrel)	DTaP + IPV
Comvax (Comv)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pedrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B
Daptacel	DTaP	Gardasil	HPV4	PedvaxHB	Hib	Rotarix	Rotavirus (RV1)
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	Rotatag	Rotavirus (RV5)

**Vaccine Abbreviations in alphabetical order** (For updated lists, visit <http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf>)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	OPV	Human Papillomavirus	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	VAR or VZV	Varicella

**Reference Guide**

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388). DOH 348-013 January 2010