



Staff Use Only

Date Received: _____
Received by: _____
Date Processed: _____

Child Care Early Learning Application

Date: _____

☐ Child Care Center (Poulsbo) ☐ Learning Center (Poulsbo) ☐ Early Learning Center (Silverdale)

CHILD/FAMILY INFORMATION

Child's First Name: _____ Last Name: _____
Child Resides With: _____ Gender: _____ Birth Date: _____
Parent/Guardian: _____ Day Phone: _____
Address: _____ Evening Phone: _____
Employer: _____ Other Phone: _____
Parent/Guardian: _____ Day Phone: _____
Address: _____ Evening Phone: _____
Employer: _____ Other Phone: _____
Primary Email for Billing/ Parent Communication: _____
Additional Email (optional): _____
Other Children in Household: _____

AUTHORIZATIONS

(Person listed must be at least 18 years old; ADDRESS REQUIRED)

In case of emergency (if parents cannot be reached), please contact the following who have permission to remove my child from the center:

Name	Full Address	Phone
_____	_____	_____
_____	_____	_____

Other persons permitted to remove my child from the center:

Name	Full Address	Phone
_____	_____	_____
_____	_____	_____

Note: We request notification in advance if someone other than the parent will be removing the child.

Persons RESTRICTED from picking up OR visiting (please attach legal documentation if available):

Name	Full Address	Phone
_____	_____	_____
_____	_____	_____

HEALTH CONTACT INFORMATION

Doctor: _____
Address: _____
Insurance Provider: _____

Phone: _____
City/Zip: _____
Policy #: _____

Dentist: _____
Address: _____
Insurance Provider: _____

Phone: _____
City/Zip: _____
Policy #: _____

HEALTH AND PERSONAL INFORMATION

Date of last physical exam: _____ Date of last dental exam: _____

Is your child on regular medication: ☐ Yes ☐ No

If yes please name medication and dosage: _____

Does your child have any allergies: ☐ Yes* ☐ No

If yes please list: _____

Does your child have any intolerance: ☐ Yes* ☐ No

If yes please list: _____

**If yes, Allergy and Intolerance Health Plan form must be received before start date.*

Has the child had the following: ☐ Measles ☐ Mumps ☐ Chickenpox ☐ Whooping Cough
☐ Rheumatic Fever ☐ Scarlet Fever

Does the child have or had any of the following conditions:

	No	Yes		No	Yes
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions, fainting	<input type="checkbox"/>	<input type="checkbox"/>	Serious injury, concussion	<input type="checkbox"/>	<input type="checkbox"/>
Sprains, dislocations, fractures	<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Operations	<input type="checkbox"/>	<input type="checkbox"/>	Urinary infections	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

Does your child need special protection from fatigue or infection: ☐ Yes ☐ No

If yes please list: _____

Can your child have vigorous exercise: ☐ Yes ☐ No

If no please explain: _____

Does your child have any health problems that necessitate special care: ☐ Yes ☐ No

If yes, please explain: _____

HEALTH AND PERSONAL INFORMATION (CONT'D)

Does the child have any vision or hearing problems: ☐ Yes ☐ No

If yes, please explain: _____

Additional health comments/information: _____

PERSONAL HISTORY

Age child began speaking: _____

Does the child speak any other language other than English: _____

If yes, what languages: _____

Does he/she have any unique words or sounds to express wants or needs: _____

Would you describe your child as: ☐ Active ☐ Quiet

What are your child's favorite toys: _____

Methods most effective for dealing with misbehavior: _____

Methods most effective for dealing with positive behavior: _____

SOCIAL HISTORY

Has the child had play experience with other children: ☐ Yes ☐ No Ages: _____

Has the child had previous experience in a childcare setting: ☐ Yes ☐ No

Does the child know other children enrolled in the center: ☐ Yes ☐ No

If so, who: _____

By nature, is the child: ☐ Friendly ☐ Shy ☐ Other: _____

How does the child express anger or frustration: _____

In your opinion, is your child ready for supervised play with others: ☐ Yes ☐ No

EATING/SLEEPING HABITS		
Does the child eat with:	<input type="checkbox"/> Spoon	<input type="checkbox"/> Fork <input type="checkbox"/> Hands
Does the child feed himself/herself:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
General attitude towards eating: _____		
Special likes/dislikes: _____		
General nightly sleep from _____ pm to _____ am		
Typical afternoon nap: <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> Other: _____		
Mood upon awakening: _____		

TOILETING	
Is child toilet trained:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, at what age:	_____ years _____ months
If no, what assistance does the child need:	_____
Can child indicate toileting wishes:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how:	_____
Does the child:	<input type="checkbox"/> Have accidents <input type="checkbox"/> Wet the bed at nap <input type="checkbox"/> Wet the bed at night
To what degree can the child dress himself/herself:	_____

[illegible]

PARENT AUTHORIZATION

Walking Trips: I give permission for my child to leave for outdoor exercise, IGP and educational purposes, with the understanding that my child will be accompanied by center staff and under proper supervision at all times.

Transportation: I give permission to Martha and Mary Children's Services to transport my child to and from the site on field trips and other activities. I will be given a specific permission slip for each off-site field trip. Off-site field trips and all transportation of children will meet state child care licensing regulations and center policies including minimum-age requirements.

Medical Emergencies: I give the Martha and Mary staff authorization to administer first aid to my child as necessary. In the event I cannot be reached, I give the Martha and Mary staff permission to obtain medical care for my child. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment. I expect that a conscientious effort will be made to locate my designees or myself. I will accept any expenses incurred.

Photographs/Videotape:

_____ I give permission for my child to be photographed and videotaped in the center and during program functions and field trips. I understand that photographs/videos may be taken by center staff or by parents/guardians and may be shared via email to family members.

_____ I give permission for my child(ren) to be photographed, or their images recorded for print or electronic use in promoting our child care services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation.

Policy: I acknowledge that I have received and understand the Martha & Mary Kids parent information packet and agree to abide by the policies stated therein. I fully understand the rights, responsibilities, and relevant facility policies and procedures. I acknowledge that I understand and agree to abide by the policies of Martha and Mary.

Signature of Parent/Guardian: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

Office only:

_____ Court documents on file; staff notified of restriction. Date court documents expire: _____
Director Initials & Date

_____ Allergy & Intolerance form received and signed off by physician if required; staff notified and training plan in place.
Director Initials & Date

_____ USDA Medical Disability Statement for Food Substitution(s) received; staff notified and training plan in place.
Director Initials & Date

_____ Health Plan received and signed by physician; staff notified and training plan in place.
Director Initials & Date



Child's Name: _____

Center: _____

☐ New Enrollment ☐ Updated

Enrollment Agreement Financial Information

CENTER HOURS OF OPERATION

The center is open from 5:30 a.m. to _____ p.m., Monday through Friday. Centers will be closed in observance of the following holidays: New Year's Day, President's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving, the day after Thanksgiving, and Christmas Day. In addition, centers will close at 4pm on Christmas Eve.

I understand that, in accordance with childcare licensing regulations, my child may be released to the custody of Child Protective Services or other local authorities if I (*or other authorized persons*) fail to pick up my child and/or contact the center and I (*or other authorized persons*) cannot be reached within 30 minutes after close-of-business.

The center will be open whenever possible on regularly scheduled days, during normal business hours. The procedure for notifying families of delays and closures due to inclement weather and/or emergencies will be posted at each center. If it becomes necessary to close early, it will be my responsibility to arrange for my child's prompt pick-up.

FEE SCHEDULE AND FINANCIAL TERMS

1. I agree that, in consideration of admission to Martha & Mary Kids and the rendering of services to my child(ren), I am obligated to pay all charges incurred in accordance with the payment regulations and current rate schedules of Martha & Mary Kids. The rate includes the cost of daily care and all meals for children over the age of one year, except when severe allergies preclude the Center meeting the child's food needs. Certain other charges (including, but not limited to, diapers, field trips, mats, late fees and ten hour fees) will also be billed as appropriate.
2. In addition to the registration fee and mat fee due upon application, an advance payment of 50% of one month's tuition is required. This payment is applied to the first month's charges, and is non-refundable if the child does not attend. A new initial registration fee may be required before enrollment may continue.
3. I understand that a new registration fee will be charged in January each year for any child that has been in attendance for greater than 3 months.
4. Payments are due by the 20th of each month. A late charge is assessed on accounts not paid in full by midnight on the 24th of the month. Accounts not made current by the last day of the month are in default and childcare services will be suspended until the account has been paid in full. I understand that a new registration fee may be required in order for my child(ren) to return. Past due accounts bear interest in the amount of 12% per annum. Should the account be referred to an attorney for collection, the undersigned agrees to pay reasonable attorney's fees and all collection expenses.
5. Martha & Mary will not be responsible for unbalanced ledgers due to parent/guardian disputes. If a bill is paid by more than one party, the division of fees is strictly the responsibility of the parties involved.
6. Tuition fees are not subject to pro-ration for absences, illnesses or emergency closure of the center. I understand that tuition is based on a contracted schedule and that I may add days at the drop in rate if space is available.
7. I agree that I will pay the full tuition fee, even if my child(ren) is absent for one or more scheduled days. I understand I will receive up to 10 vacation days per calendar year. Vacation day requests must be submitted to the center management and will be charged at a discounted rate of 50%.

Child's Name: _____ Center: _____

8. A late pick up fee will be assessed (per child) when a child attends past close-of-business. I understand that late pick up fees are due on the day of service, and must be paid before my child(ren) returns to care the following day. The late pick up fee does not constitute as agreement to provide after-hours services.
9. A check return fee will be assessed on all returned checks. Payments from customers with prior outstanding redeemed returned checks must be in the form of a money order or cashier's check. Returned check activity may be subject to immediate termination of services.
10. Two weeks' written notice is required prior to the last day of attendance. If I do not give proper notice, I agree to pay any fees or full tuition that may be due for the final two weeks, regardless of my child(ren)'s attendance. I also understand any prepaid funds of \$20.00 or less which remains at the time of my child's disenrollment will not be remitted to me unless requested in writing within 90 days.
11. Where other parties such as state or federal agencies (DSHS) pay a portion or all of the childcare charges, I hereby agree to pay my participation of the charges, or all charges for any period the child is determined to be ineligible for the program, as well as all charges incurred which are properly charged toward the child under such programs. I understand it is my responsibility to ensure that coverage with outside agencies is kept current and up to date. I understand that reauthorization of eligibility must be received from DSHS before the current end date of authorization or enrollment will be terminated. Re-enrollment will not be guaranteed, and will not be considered until such time as proof of eligibility is provided.
12. When seeking to obtain financial assistance through DSHS, I understand that DSHS coverage will be effective as of the date of receipt and that "back-dating" is not accepted, even if authorized by DSHS.

DISCOUNTS AND PAYMENT

Only one discount per family is available. Discounts do not apply to families receiving subsidy. For families with multiple children in our care, the discount is applied to the oldest child's tuition. Discounts are applied to scheduled days only.

Payment Type (select one):

- ☐ Private Pay
- ☐ Employee*
- ☐ DSHS*

**additional forms attached*

Discounts (one per family):

- ☐ Sibling Discount
- ☐ Military Discount*
- ☐ CKSD or NKSD Employee Discount

ACKNOWLEDGMENT

I certify that I have read, understand and accept all of the terms and conditions in this Agreement. This Agreement will be effective as of _____, _____ (child's start date OR change effective date).

Primary Parent/Guardian Signature _____ Date _____

Center Director Signature _____ Date _____

Staff Use Only

Date received: _____

By: _____

Date orientation held: _____

By: _____

Additional forms obtained:

- ☐ DSHS Award Letter
- ☐ Employee Payroll Deduction Authorization
- ☐ DSHS Policies Agreement
- ☐ Military Discount Form

Child's Name: _____ Center: _____

☐ New Enrollment ☐ Updated Fee Agreement ☐ Revised Schedule Only

SCHEDULED ATTENDANCE

Tuition fees are based on the following scheduled attendance. I understand I will be charged additional tuition fees if my child's attendance extends beyond the schedule submitted below. I understand I may add days (*if space is available*) at the drop in rate. **If long term schedule changes are needed I understand it must be submitted in writing to the Center Director for authorization by the 15th of the previous month and once approved a new financial agreement with contracted days is required.**

I agree to notify the center staff by 9:00 a.m. if my child will not be in attendance on a scheduled day.

My child will attend on the following days and times:

	Arrival	Departure	Arrival	Departure
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				

I understand there is an additional fee for each day that my child is either scheduled for more than 10 hours or is in attendance for more than 10 hours.

☐ I will need care for my child over 10 hours per day due to _____
_____.

AUTHORIZATION

The schedule listed above will effective as of _____, _____ (*child's start date OR change effective date*).

Primary Parent/Guardian Signature	Date

Center Director Signature	Date



Child and Adult Care Food Program Child Care Centers

Dear Parents:

Our center does not charge separately for meals because it participates in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). This program pays centers for nutritious meals served to all children while in care.

How much does the center receive in payment for meals served to my child while in care?

The amount of payment received is based on the income status of the families in our center. We receive a higher payment for those families that are low-income.

How do you determine the income status of my family?

The information you provide on the enclosed Enrollment/Income-Eligibility Application determines the income status and payment level.

I'm not sure if my family income qualifies. How do I decide?

If your gross income (before deductions) is the same as or less than the amount on the line for your family size on the income guidelines table below, the center is eligible for the higher payment for your child(ren). When self-employed, net income may be reported. Please complete and return the Enrollment/Income-Eligibility Application to our office as soon as possible.

Income Guidelines Reduced-Price Meals

Effective July 1, 2016–June 30, 2017

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	\$ 21,978	\$ 1,832	\$ 916	\$ 846	\$ 423
2	29,637	2,470	1,235	1,140	570
3	37,296	3,108	1,554	1,435	718
4	44,955	3,747	1,874	1,730	865
5	52,614	4,385	2,193	2,024	1,012
6	60,273	5,023	2,512	2,319	1,160
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
Each additional household member add:	+ 7,696	+ 642	+ 321	+ 296	+ 148

If I receive payment from DSHS for child care, should I complete these forms?

Yes. DSHS payments for child care do not qualify a family for the higher payment.

If my household income is greater than the income guidelines for reduced-price meals, or if I choose not to report my income, what should I do?

You should complete Parts 1 and 5 and may write “above-scale” in Part 4.

If I choose not to report my household income, do I still need to return the Enrollment/Income-Eligibility Application?

Yes. If you choose not to fill out the income portion of the Enrollment/Income Eligibility Application (E/IEA), you must still complete Part I, the “Children’s Information” section, and Part 5. Federal regulations require that all child care centers collect information on the normal days and hours child(ren) are expected to be in care and the expected meals to be received.

Is there another way for the center to receive the higher payment other than using my family income?

Yes. Your child(ren) may be eligible for the higher payment based on one of the following:

1. You receive Basic Food, Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) for any member of your household.
2. Your child is a foster child.

If a household member currently receives benefits from one of these programs, or I believe my family income would qualify my child, what should I do?

Complete the attached Enrollment/Income-Eligibility Application, following the directions on the form. There is a separate section for each way your child may qualify.

Will this information be kept confidential?

Yes. The information will be made available only to a limited number of our staff or employees of the Office of Superintendent of Public Instruction, U.S. Department of Agriculture, or the U.S. General Accounting Office when they are reviewing our program.

Will the center make menu substitutions for my child?

If your child has been determined by a doctor to be disabled, and the disability would prevent the child from eating the regular meals at the center, we will make any substitutions prescribed by the doctor at no extra charge.

What do I need to bring to the center if my child needs menu substitutions?

You must bring the doctor’s note that prescribes the alternative foods needed and verifies special meals are needed due to the disability.

Whom should I contact if I have any questions?

Contact our office at Phone Number.

Thank you for helping us provide healthy meals for your child.

Sincerely,

Signature of Center Director

In the operation of the child feeding programs, no child will be discriminated against because of race, color, national origin, sex, age, or disability.

Child and Adult Care Food Program ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

- ☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)
- ☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)
- ☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)
- ☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD, TANF, OR FDPIR—Only one household member receiving benefits must be listed in order to establish eligibility for all children in the household.

Name	Circle One	Case Number or Identification Number
	Basic Food TANF FDPIR	

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

List names (First and Last) of everyone in your household, including foster children	Gross Income from Last Month (or net income if self-employed) Tell us how much and how often. If no income, write "0".			
	Earnings from Work Before Deductions	Alimony, Child Support	Retirement, Pensions, Social Security	Job Two or Any Other Income
Jane Smith (example)	\$1000 / month	\$300 / month		\$100 / week
1.	\$ /	\$ /	\$ /	\$ /
2.	\$ /	\$ /	\$ /	\$ /
3.	\$ /	\$ /	\$ /	\$ /
4.	\$ /	\$ /	\$ /	\$ /
5.	\$ /	\$ /	\$ /	\$ /
6.	\$ /	\$ /	\$ /	\$ /

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) **If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the Social Security Number is not needed.**

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Signature of Adult	Date	Print Name of Adult Signing	<input type="checkbox"/> I do not have a Social Security Number
		Social Security Number (last four digits) XXX-XX-	
Address		City/State/Zip Code	Daytime Phone

PART 6 – CHILDREN’S ETHNIC AND RACIAL IDENTITIES—You are not required to answer this part.

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, sex, age, or disability.

Race:

- ☐ White
☐ Black or African American
☐ Asian
☐ American Indian or Alaskan Native
☐ Native Hawaiian or Pacific Islander
☐ Multi-Racial

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Basic Food, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

CENTER USE ONLY

☐ Child(ren) are categorically free based on ☐ Basic Food ☐ TANF ☐ FDPIR

☐ Foster child(ren) have been identified on this form and qualify for the free category.

Annual Income Comparison: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

☐ Child(ren) on this form who are not categorically eligible qualify as follows:

Check one: ☐ Free
☐ Reduced-Price
☐ Above-Scale

Total Income: \$ _____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

Signature of Institution's Representative

Date

Not valid without signature and date.

EIEA Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the EIEA within these guidelines, the institution representative's signature date must be used as the effective date.

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 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.

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other:
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	

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

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 ►

#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.

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

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	<i>Haemophilus influenzae</i> type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vaccine	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

Certificate of Exemption

SIDE A:
For Religious, Personal,
Philosophical, and Medical
Exemptions¹

FOR OFFICE USE ONLY CHILD'S LAST NAME

FIRST NAME

M.I.

PART 1: PARENT OR GUARDIAN INSTRUCTIONS

In order for this form to be valid for religious, personal, philosophical, or medical reasons, please:

- Step 1:** Fill in your child's information in Boxes 1-4
- Step 2:** Read the Parent/Guardian Declaration
- Step 3:** Provide your initials where indicated
- Step 4:** Print your name, sign, and date in Boxes 5-6
- Step 5:** Have a provider complete Part 2 of this form

1. Child's Last Name

2. Child's First Name and Middle Initial

3. Birthdate (mm/dd/yyyy)

4. Gender

- ☐ Male
☐ Female

I am the parent or legal guardian of the above named child. One or more required vaccines are in conflict with my personal, philosophical, or religious beliefs.

Parent/Guardian Declaration

I understand that:

- My child may not be allowed to attend school or child care during an outbreak of the disease that my child has not been fully vaccinated against. _____ (initial)
- Exempting my child from any or all required vaccine(s) may result in serious illness, disability, or death to my child or others. I understand the risks and possible outcomes of my decision to exempt my child. _____ (initial)
- The information provided on this form is complete and correct. _____ (initial)

5. Print Parent/Guardian Name

6. Parent/Guardian Signature and Date

PART 2: HEALTHCARE PROVIDER INSTRUCTIONS

In order for this form to be valid, please:

- Step 1:** Mark which disease(s) and what type of exemption is requested. If medical write a **T** for Temporary or **P** for Permanent.
- Step 2:** Discuss the benefits and risks of immunizations with the parent or guardian
- Step 3:** Read the Provider Declaration
- Step 4:** Print your name, credentials, sign, and date in Boxes 7-8

Vaccine	Personal/ Philosophical	Religious	Medical (T/P)**	Expiration Date for Temporary Medical
Diphtheria				
Hepatitis B				
Hib				
Measles				
Mumps				
Pertussis				
Pneumococcal				
Polio				
Rubella				
Tetanus				
Varicella				
All				

****A provider may grant a medical exemption only if there is a medical contraindication to a vaccine.**

Provider Declaration

I declare that:

- I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child.
- I am a qualified MD, ND, DO, ARNP or PA licensed under Title 18 RCW.
- The information provided on this form is complete and correct.

7. Print Provider Name and Credential (MD, ND, DO, ARNP, PA)

8. Provider Signature and Date

¹RCW 28A.210.080-090 "Before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the State Board of Health, or (3) a certificate of exemption signed by a parent or guardian and is either A) signed by a licensed healthcare provider or B) demonstrates membership in a church or religious body that precludes healthcare practitioners from providing medical treatment to children."

Certificate of Exemption

SIDE B:
For Religious Membership
Exemption ONLY

FOR OFFICE USE ONLY CHILD'S LAST NAME

FIRST NAME

M.I.

NOTICE: Complete this side if you belong to a church or religion that objects to the use of medical treatment.¹

If you have a religious objection to vaccinations, but the beliefs or teachings of your church or religion allow for your child to be treated by medical professionals such as doctors and nurses, then you must use Side A of this Certificate of Exemption.

PARENT OR GUARDIAN INSTRUCTIONS

In order for this form to be legally valid for religious membership reasons, please:

Step 1: Fill in your child's information in Boxes 1-4

Step 2: Read the Parent/Guardian Declaration and provide your initials where indicated

Step 3: Provide the name of the church or religion of which you are a member, and print your name, sign, and date in Boxes 5-7

1. Child's Last Name

2. Child's First Name and Middle Initial

3. Birthdate (mm/dd/yyyy)

4. Gender

☐ M ☐ F

I am the parent or legal guardian of the above named child and I am exempting my child from all required vaccinations.

Parent/Guardian Declaration

I understand that:

- My child may not be allowed to attend school or child care during an outbreak of the disease that my child has not been fully vaccinated against. _____ (initial)
- Exempting my child from all required vaccines may result in serious illness, disability, or death to my child or others. I understand the risks and possible outcomes of my decision to exempt my child. _____ (initial)
- The information provided on this form is complete and correct. _____ (initial)

I affirm that I am a member of a church or religion whose teachings preclude healthcare practitioners from providing any medical treatment to my child.

5. Name of Church or Religion of Which You Are a Member

6. Print Parent/Guardian Name

7. Parent/Guardian Signature and Date

¹RCW 28A.210.090 "The parent of legal guardian demonstrates membership in a religious body or a church in which the religious beliefs or teachings of the church preclude a health care practitioner from providing medical treatment to the child."