La Center School District

RESIDENCY VERIFICATION DECLARATION FORM

(Please complete one form for each student)

☐ HOME OWNER
☐ RENTER
☐ OTHER (specify) _____

Washington law requires schools to be open to the admission of all persons between the ages of 5 and 21 residing in that school district (RCW 28A.225.160). The La Center School District (District) is required to take appropriate steps to ensure that students attending its schools satisfy applicable laws. This Residency Verification Form must be completed, signed, and submitted with appropriate documentation demonstrating compliance with Washington residency laws.

DO NOT SIGN THIS FORM IF ANY OF THE STATEMENTS ARE INCORRECT. Evidence that false information was provided may be cause for immediate revocation of the student's school assignment and withdrawal from the District.

Student: _____ Current School: _____ Current Grade: _____
Last Name First Name

Parent/Guardian: _____ Home Phone: _____

Address: _____
Number Street City State Zip Code

Email Address: _____

NOTE: The District presumes that the person who enrolls a student in school is the residential parent of the student. In circumstances in which legal and physical custody of the student is shared between two parents, you must provide a certified copy of the court order identifying each parent's respective legal and physical custody rights. You also must inform the District of any changes to the court order within (5) days.

In compliance with WAC 392-137-115, by signing below I acknowledge the following:

- My student (listed above) resides with me at least four (4) nights per week at the address listed above which is my primary residence.
- I agree to notify and provide updated proof of residency to the District/School within (5) days of when I change my residence or that of my student to a new address, either within or outside the District.
- The District will investigate all cases where it has reason to believe that residency status has changed and/or false information has been provided, which may include home visits to verify residency.
- Investigations that reveal students have enrolled on the basis of providing false information may result in the revocation of the student's school assignment and withdrawal from the District.
- I have attached the following two (2) *Proof of Residency documents which include my name and residential address.

☐ Current payroll check stub with name and address
☐ Government issued check or correspondence
☐ Public agency documents (DSHS, courts, etc.)
☐ Mortgage, rental or lease documents
☐ Homeowners or Renters Insurance Policy
☐ Utility bill(s) (water, sewer, gas, electric, cable, etc.)

*Personal correspondence or copies of envelopes are not acceptable Proof of Residency documents.

I swear (or certify) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct, and that any and all copies of documents submitted to verify my residency are true and correct copies of the original documents, and that any and all documents submitted have not been altered except for the crossing out of dollar amounts and account numbers (redacted), which is permitted for the purposes of this Residency Verification Declaration.

_____
Printed Name of Parent/Guardian

_____ _____
Signature of Parent/Guardian Date

Student Records Request

La Center School District, No. 101
La Center, Washington

Form Sent _____
Records Received_____

Student Legal Name: _____ Date of Birth: ___/___/___

Other Names Used: _____ Grade: _____

Previous School Information

School Name: _____

School Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

The student listed above has registered at the following school:

☐ La Center Elementary School PO Box 1810 La Center, WA 98629 P: 360-263-2134 F: 360-263-2133 E: joyce.hantho@lacenterschools.org	☐ La Center Middle School PO Box 1750 La Center, WA 98629 P: 360-263-2136 F: 360-263-5936 E: rochelle.wilson@lacenterschools.org	☐ La Center High School PO Box 1780 La Center, WA 98629 P: 360-263-1700 F: 360-263-5577 E: beth.marshall@lacenterschools.org	☐ La Center Home School Academy PO Box 1780 La Center, WA P: 360-263-2131 Ext. 230 F: 360-263-5577 E: beth.marshall@lacenterschools.org

SCHOOLS: Please send copies of all permanent records that will assist in planning and carrying out this student's educational program including, but not limited to:

- Birth Certificate (Fax ASAP)
- State Assessment Scores
- Discipline Records
- Academic History/Report Cards/Withdrawal Grades
- Culminating Project/HS & Beyond Plan
- Immunizations (Fax ASAP)
- Attendance History
- Official Transcript (Fax Unofficial Transcript ASAP)
- Fines/Fees
- Health Records

PARENTS: Please indicate if this student was enrolled in any special programs listed below.
SCHOOLS: Please verify special programs and return a copy of this form with records for the selected programs:

☐ ELL ☐ Gifted/Highly Capable ☐ 504 Plan ☐ Title I/LAP Math ☐ Title I/LAP Reading

☐ Special Education--Please circle what area(s) student was served and include the most recent IEP and assessment: Reading/Writing/Math/Behavior/Social/OT/Speech
Placement: Inclusion/Resource Room/Self-Contained/Life Skills
IEP Case Manager: _____ Phone Number: _____

For internal use—Copy sent to Special Education Department ☐

As provided under the Family Educational Rights and Privacy Act (FERPA), I understand that I may obtain a copy of my child's educational records. I am aware that I may challenge the content of these records. I also understand that the school will treat these records confidentially and that the records will not be disclosed to a non-educational agency without my written permission.

Parent/Guardian Signature: _____ Date: _____

Registrar Signature: _____ Date: _____

La Center School District #101
725 Highland Road La Center, WA 98629
Student Housing Questionnaire

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. The McKinney-Vento Act provides services and supports for children and youth experiencing homelessness or housing instability. (Please see reverse side for more information.)

If you own/rent your own home, you do not need to complete this form.

Please check which box reflects your current living situation:

☐ In a motel
☐ In a shelter
☐ Moving from place to place/couchsurfing
☐ In someone else's house or apartment with another family
☐ In a residence with inadequate facilities (no water, heat, electricity, etc.)
☐ A car, park, campsite, or similar location
☐ Transitional Housing
☐ Other _____

Name of Student: _____
First Middle Last

Name of School: _____Grade:_____Birthdate: _____ Age: _____
Month/Day/Year

Gender: _____ ☐ Student is unaccompanied (not living with a parent or legal guardian)
☐ Student is living with a parent or legal guardian

Address or 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: _____ Date: _____
(Or Unaccompanied Youth)

*I declare under penalty of perjury under the laws of the State of Washington that the information provided here is true and correct.

McKinney-Vento Building Liaison Signature_____ Date_____
I hereby certify that the above named student qualifies for rights and services under the McKinney-Vento Act.

McKinney-Vento District Liaison Signature_____ Date_____
La Center School District 360-263-2136

Rev 10/2016

McKinney-Vento Act 42 U.S.C. 11435

SEC. 725. DEFINITIONS.

For purposes of this subtitle:

(1) The terms enroll' and enrollment' include attending classes and participating fully in school activities.

(2) The term homeless children and youths' —

(A) means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1)); and

(B) includes —

(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C));

(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

(6) The term unaccompanied youth' includes a youth not in the physical custody of a parent or guardian.

Additional Resources

Parent information and resources can be found at the following:

http://center.serve.org/nche/ibt/parent_res.php
http://naehcy.org/educational-resources/naehcy-publications

La Center School District
Student Health History ____/____ School Year

Student Name: _____ Date of Birth: _____Grade: ____ ☐ Male ☐ Female

Parent Name: _____Phone #: _____Teacher: _____Bus#____

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:

If your child has a life-threatening condition, state law requires medication and/or treatment orders from a Licensed Health Professional and an Emergency Care Plan tobe in place before your child can attend school. *Please check appropriate boxes below and explain if needed.*

Health Condition	Yes	No	Explanation if "Yes" checked
Food Allergies	☐	☐	**Food(S): ☐ peanut ☐ tree nut ☐ dairy ☐ eggs ☐ other_____ Rate the reaction: ☐ mild ☐ moderate ☐ life-threatening Does your child require an EpiPen? ☐ yes ☐ no**
Allergy to Bee Stings	☐	☐	**Rate the reaction: ☐ mild ☐ moderate ☐ life-threatening Does your child require an EpiPen? ☐ yes ☐ no**
Medication Allergies	☐	☐	**List:**
Allergies (other)	☐	☐	**List:**
Asthma	☐	☐	**Rate the severity: ☐ mild ☐moderate ☐ life-threatening Asthma medication taken at home:_____ Medication required at school:**
Diabetes	☐	☐	**☐Type 1 (insulin Dependent) ☐Type 2 Diabetes medications(s) taken at home:**
Seizure Disorder	☐	☐	**Type of seizure: Medications:**
Heart Condition	☐	☐	**Specify:**
Cancer	☐	☐	**Specify:**
Blood Disorder	☐	☐	**Specify: Treatment:**
ADD/ADHD	☐	☐	**Medication for ADD/ADHD:**
Mental Health / Behavioral Issues	☐	☐	**Specify: Treatment/Medication:**
Orthopedic Condition	☐	☐	**Specify:**
Wears glasses	☐	☐	**☐ For Distance ☐ For Reading**
Hearing Loss	☐	☐	**Hearing Loss ☐ Right Ear ☐ Left Ear ☐ Hearing Aids**

Does your child have any other condition that would affect his/her classroom performance or P.E. activities?

☐ No ☐ Yes if yes, explain: _____

Daily Medication

State law requires written permission from a Licensed Health Professional and parent before any medication (prescription or over-the-counter) can be given at school. A form is available from the school office.

☐ No ☐ Yes Medication needed at school- specify: _____

☐ No ☐ Yes Medication needed at home- specify: _____

☐ No ☐ Yes For daily medication taken at home, would missing 24 hours of this medication pose a health risk to your child or others? If yes, a three-day supply of medication would need to be supplied to the school in case of an emergency (ex. daily asthma, diabetes, seizure, allergy or ADD/ADHD medication).

This information is considered confidential. It will be shared with school staff and emergency responders as needed during the time your child is enrolled in La Center School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.

Parent/guardian signature: _____Date:_____

LA CENTER SCHOOL DISTRICT

FAMILY EMERGENCY PLAN

Should an emergency closure of school be necessary, each family needs to have prepared a plan for supervision of your child. Please discuss with your child to whom they should report if you are not home when they arrive. It is especially helpful for children to have at least two alternatives for safe supervision. Children will be more assured if the family has actually practiced the routine of what to do if parents are not home to meet them. Emergency closures of school are extremely rare. However, we need to prepare our children for a safe experience should the need arise. If we do not have an alternative plan, your child will be sent home according to their regular routine.

Please specify below any specific instructions for the school staff in the event of an unannounced early dismissal. Parents/Guardians will be notified via School Messenger in the event of a closure.

PHONE CALLS FROM SCHOOL CANNOT BE A PART OF THIS PLAN

Student's Name: _____

Grade: _____ Teacher: _____

List Siblings with Grade Level and Teacher

_____
_____
_____
_____
_____
_____
_____

☐ **Ride the bus home as usual.**

Special instructions. Please include any alternate bus numbers.

_____
_____
_____

Parent signature: _____

Date: _____ Phone: _____

La Center School District

P.O. Box 1840, 725 Highland Rd. La Center, WA 98629

Authorization For Administration Of Medication

(Oral medications, Inhalers, Epi-pens, Insulin, Eye, Ear, and Topical Medications)

For questions contact the school nurse:

Phone: 360-263-2134 ext.218 Fax:360-263-2133

Student Name:_____ Birth Date:_____ Sex: M / F

School:_____ Teacher:_____ Grade: _____

HEALTH CARE PROVIDER completes this section: (please print)

I have determined that the medication named below is necessary during the school day:

Diagnosis or reason for medication:_____

Name of medication:_____ Dose:_____

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other_____

If medicine is given DAILY, at what time? _____

If medicine is to be given WHEN NEEDED, describe indications: _____

_____

How soon can it be repeated?_____

Is student allowed to carry and self-administer emergency medication? *Yes* ☐ *No* ☐
I have trained this student in the purpose and appropriate method and frequency of use. *Yes* ☐ *No* ☐
Medication authorizations are only valid for current school year.

Significant side effects: _____

Date:_____ Health Care Provider Signature: _____

Phone #:_____ Print Name: _____

Fax #:_____ Address: _____

PARENT/GUARDIAN completes this section:

I request that my child be allowed to take the medication as described above.
I request that authorized school staff assist my child in taking the medication(s) described above.
I understand that school staff will attempt to administer medication in a timely manner.
I will provide the medication in the original, properly labeled container.
I give my permission for the exchange of information regarding this medication between the school staff and health care provider. I authorize my student to self-carry inhaler/rescue medication. ☐ Yes ☐ No

_____	_____	_____	_____
(Date)	(Parent/Guardian Signature)	(Daytime Phone)	(Emergency Phone)

(OVER)

SCHOOL MEDICATION POLICY

Whenever possible we encourage medication doses to be scheduled during non-school hours.

For those students who need medication at school, the following is required by Washington State Law (RCW 28A.210.260 and 270) and must be completed and on file **BEFORE** any medication may be given. See also district policy and procedure 3416 and 3416P Medication at School.

OVER-THE-COUNTER and NON-PRESCRIPTION MEDICATIONS/PRODUCTS

- Authorization for Administration of Medications Form **completed by both parent/guardian AND a licensed health care professional with prescriptive authority**.
- MUST be in original container labeled with the student's name.

PRESCRIBED MEDICATION

- Authorization for Administration of Medications Form **completed by both parent/guardian AND a licensed health care professional with prescriptive authority**.
- Medication must be in a properly labeled container from the dispensing pharmacy. A pharmacy can provide a labeled container for school upon request.
    - Student's name
    - Name, Strength and Dose of Medication
    - Time and Mode of Administration
- Provide no more than a 20 day supply.

PLEASE NOTE:

- Requests for the administration of oral medication are valid only for the medication listed and the dates indicated. Requests for medication administration must be re-authorized each school year.

- **All medications will be kept in the school office unless otherwise directed by the Health Care Provider. Medications stored in this area may not be available to the student during non-school hours.**
- **It is the responsibility of the parents/guardians to assure that necessary emergency (rescue) medications are available to their students after school hours and while traveling to/from and during after school events.**

Thank you for your cooperation.

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

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

Student Name:	**Grade:**	**Date:**

Parent/Guardian Name _____ Parent/Guardian Signature _____

Right to Translation and Interpretation Services
Indicate your language preference so we can provide an interpreter or translated documents, free of charge, when you need them.

All parents have the right to information about their child's education in a language they understand.

1. In what language(s) would your family prefer to communicate with the school?
   _____

Eligibility for Language Development Support
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.

2. What language did your child learn first?
   _____
3. What language does your child use the most at home?
   _____
4. What is the primary language used in the home, regardless of the language spoken by your child?
   _____
5. Has your child received English language development support in a previous school? Yes___ No___ Don't Know___

Prior Education

Your responses about your child's birth country and previous education:

- Give us information about the knowledge and skills your child is bringing to school.
- May enable the school district to receive additional federal funding to provide support to your child.

This form is not used to identify students' immigration status.

6. In what country was your child born? _____
7. Has your child ever received formal education outside of the United States? (Kindergarten – 12th grade) _____Yes _____No

   If yes: Number of months: _____
   Language of instruction: _____
8. When did your child first attend a school in the United States? (Kindergarten – 12th grade)

   _____
   Month Day Year

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.*

Certificate of Immunization Status (CIS)

Reviewed by:	Date:
Signed COE on File? □ Yes □ 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** **Date**	X _____ **Parent/Guardian Signature Required if Starting in Conditional Status** **Date**

▲Required for School ● Required Child Care/Preschool	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
●▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)						
●▲ DT or Td (Tetanus, Diphtheria)						
●▲ Hepatitis B						
● Hib (*Haemophilus influenzae type b*)						
●▲ IPV (Polio) (any combination of IPV/OPV)						
●▲ OPV (Polio)						
●▲ MMR (Measles, Mumps, Rubella)						
● PCV/PPSV (Pneumococcal)						
●▲ Varicella (Chickenpox) ☐ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

Documentation of Disease Immunity (Health care provider use only)

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:
□ A verified history of varicella (chickenpox) disease.
□ Laboratory evidence of immunity (titer) to disease(s) marked below.

□ Diphtheria	□ Hepatitis A	□ Hepatitis B
□ Hib	□ Measles	□ Mumps
□ Rubella	□ Tetanus	□ Varicella

□Polio (all 3 serotypes must show immunity)

►

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: _____ Signature: _____ Date:_____
If verified by school or child care staff the medical immunization records must be attached to this document.

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

To print with the immunization information filled in:
Ask if your health care provider's office enters immunizations into the WA Immunization Information System (Washington's statewide registry). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.

To fill out the form by hand:
1. Print your child's name and birthdate, and sign your name where indicated on page one.
2. Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediatix under Diphtheria, Tetanus, Pertussis as DTaP, Hepatitis B as Hep B, and Polio as IPV.
3. If your child had chickenpox (varicella) disease and not the vaccine, a health care provider must verify chickenpox disease to meet school requirements.
   - □ If your health care provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
   - □ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.
4. If your child can show positive immunity by blood test (titer), have your health care provider check the boxes for the appropriate disease in the Documentation of Disease Immunity section, and sign and date the form. You must provide lab reports with this CIS.
5. Provide proof of medically verified records, following the guidelines below.

Acceptable Medical Records
All vaccination records must be medically verified. Examples include:

- A Certificate of Immunization Status (CIS) form printed with the vaccination dates from the Washington State Immunization Information System (IIS), MyIR, or another state's IIS.
- A completed hardcopy CIS with a health care provider validation signature.
- A completed hardcopy CIS with attached vaccination records printed from a health care provider's electronic health record with a health care provider signature or stamp. The school administrator, nurse, or designee must verify the dates on the CIS have been accurately transcribed and provide a signature on the form.

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. (Vaccine series doses are spread out among minimum intervals, so some children may have to wait a period of time before finishing their vaccinations. This means they may enter school while waiting for their next required vaccine dose). To enter school or child care in conditional status, a child must have all the vaccine doses they are eligible to receive before starting school or child care.

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 of vaccination. If a student is catching up on multiple vaccines, conditional status continues in a similar manner until all of the required vaccines are complete.

If the 30-day conditional period expires and documentation has not been given to the school or child care, then the student must be excluded from further attendance, per RCW 28A.210.120. Valid documentation includes evidence of immunity to the disease in question, medical records showing vaccination, or a completed certificate of exemption (COE) form.

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://www.cdc.gov/vaccines/terms/usvaccines.html

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Fluarix	Flu	Havrix	Hep A	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)
Adacel	Tdap	Flucelvax	Flu	Hiberix	Hib	Pediarix	DTaP + Hep B + IPV	RotaTeq	Rotavirus (PV5)
Afluria	Flu	FluLaval	Flu	HibTITER	Hib	PedvaxHIB	Hib	Tenivac	Td
Bexsero	MenB	FluMist	Flu	Ipol	IPV	Pentacel	DTaP + Hib +IPV	Trumenba	MenB
Boostrix	Tdap	Fluvirin	Flu	Infanrix	DTaP	Pneumovax	PPSV	Twinrix	Hep A + Hep B
Cervarix	2vHPV	Fluzone	Flu	Kinrix	DTaP + IPV	Prevnar	PCV	Vaqta	Hep A
Daptacel	DTaP	Gardasil	4vHPV	Menactra	MCV or MCV4	ProQuad	MMR + Varicella	Varivax	Varicella
Engerix-B	Hep B	Gardasil 9	9vHPV	Menomune	MPSV4	Recombivax HB	Hep B		

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 November 2019

Certificate of Exemption—Personal/Religious

For School, Child Care, and Preschool Immunization Requirements

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate (mm/dd/yyyy):**

NOTICE: A parent or guardian may exempt their child from the vaccinations listed below by submitting this completed form to the child's school and/or child care. A person who has been exempted from a vaccination is considered at risk for the disease or diseases for which the vaccination offers protection. An exempted child/student may be excluded from school or child care settings and activities during an outbreak of the disease that they have not been fully vaccinated against. Vaccine preventable diseases still exist, and can spread quickly in school and child care settings. Immunizations are one of the best ways to protect people from getting and spreading diseases that may result in serious illness, disability, or death.

Personal/Philosophical or Religious Exemption

I am exempting my child from the requirement my child be vaccinated against the following disease(s) to attend school or child care. (Select an exemption type and the vaccinations you wish to exempt your child from):

PERSONAL/PHILOSOPHICAL EXEMPTION*

☐ Diphtheria	☐ Hepatitis B	☐ Hib	☐ Pneumococcal
☐ Polio	☐ Pertussis (whooping cough)	☐ Tetanus	☐ Varicella (chickenpox)

***Measles, mumps, or rubella may not be exempted for personal/philosophical reasons per state law**

RELIGIOUS EXEMPTION

☐ Diphtheria	☐ Hepatitis B	☐ Hib	☐ Pneumococcal
☐ Polio	☐ Pertussis (whooping cough)	☐ Tetanus	☐ Varicella (chickenpox)
☐ Measles	☐ Mumps	☐ Rubella	

Parent/Guardian Declaration

One or more of the required vaccines are in conflict with my personal, philosophical, or religious beliefs. I have discussed the benefits and risks of immunizations with the health care practitioner (signed below). I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

_____ _____ _____

Parent/Guardian Name (print) Parent/Guardian Signature Date

Health Care Practitioner Declaration

I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child. I certify I am a qualified MD, ND, DO, ARNP, or PA licensed in Washington State.

_____ _____ _____

Licensed Health Care Practitioner Name (print) Licensed Health Care Practitioner Signature Date

☐ MD ☐ ND ☐ DO ☐ ARNP ☐ PA Washington License #_____

Religious Membership Exemption

Complete this section ONLY if you belong to a church or religion that objects to the use of medical treatment. Use the section above 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.

Parent/Guardian Declaration

I am the parent or legal guardian of the above-named child. I affirm I am a member of a church or religion whose teaching does not allow health care practitioners to give medical treatment to my child. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

Name of church or religion of which you are a member: _____

_____ _____ _____

Parent/Guardian Name (print) Parent/Guardian Signature Date

If you have a disability and need this form in a different format please call 1-800-525-0127 (TDD/TTY Call 711). **DOH-348-106 June 2019**

Certificate of Exemption—Medical

For School, Child Care, and Preschool Immunization Requirements

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate (mm/dd/yyyy):**

NOTICE: This form may be used to exempt a child from the requirement of vaccination when a health care practitioner has determined specific vaccination is not advisable for the child for medical reasons. This form must be completed by a health care practitioner and signed by the parent/guardian. An exempted child/student may be excluded from school or child care during an outbreak of the disease they have not been fully vaccinated against. Vaccine preventable diseases still exist, and can spread quickly in school and child care settings.

Medical Exemption

A health care practitioner may grant a medical exemption to a vaccine required by rule of the Washington State Board of Health only if in his or her judgment, the vaccine is not advisable for the child. When it is determined that this particular vaccine is no longer contraindicated, the child will be required to have the vaccine (RCW 28A.210.090). Providers can find guidance on medical exemptions by reviewing Advisory Committee on Immunization Practices (ACIP) recommendations via the Centers for Disease Control and Prevention publication, "Guide to Vaccine Contraindications and Precautions," or the manufacturer's package insert. The ACIP guide can be found at:
www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html

*Please indicate which vaccine antigen(s) the **medical** exemption is referring to. If the patient is not exempt from certain antigen(s), mark "not exempt.":*

Disease	Not Exempt	Permanent Exempt	Temporary Exempt	Expiration Date for Temporary Medical
Diphtheria	☐	☐	☐	
Hepatitis B	☐	☐	☐	
Hib	☐	☐	☐	
Measles	☐	☐	☐	
Mumps	☐	☐	☐	
Pertussis	☐	☐	☐	
Pneumococcal	☐	☐	☐	
Polio	☐	☐	☐	
Rubella	☐	☐	☐	
Tetanus	☐	☐	☐	
Varicella	☐	☐	☐	

Health Care Practitioner Declaration

I declare that vaccination for the disease/s checked above is not advisable for this child. I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child. I certify I am a qualified MD, ND, DO, ARNP or PA licensed in Washington State, and the information provided on this form is complete and correct.

_____ _____ _____

Licensed Health Care Practitioner Name (print) Licensed Health Care Practitioner Signature Date

☐ MD ☐ ND ☐ DO ☐ ARNP ☐ PA Washington License #_____

Parent/Guardian Declaration

I have discussed the benefits and risks of immunizations with the health care practitioner granting this medical exemption. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

_____ _____ _____

Parent/Guardian Name (print) Parent/Guardian Signature Date

If you have a disability and need this form in a different format please call 1-800-525-0127 (TDD/TTY Call 711). **DOH-348-106 June 2019**