

**STANWOOD-CAMANO SCHOOL DISTRICT  
REQUEST FOR PART-TIME ATTENDANCE OR  
ANCILLARY SERVICES FROM PRIVATE SCHOOL PUPIL**

*Please complete ALL information:*

Name of Pupil \_\_\_\_\_ Grade \_\_\_\_\_

Address of Pupil \_\_\_\_\_

City and Zip Code \_\_\_\_\_

Address of Parent \_\_\_\_\_

City & Zip Code \_\_\_\_\_

Name of Private School \_\_\_\_\_

Services Requested: \_\_\_\_\_

\_\_\_\_\_

Name of School Where Service is Requested \_\_\_\_\_

Transportation Services to be Used \_\_\_\_\_

\_\_\_\_\_  
*Signature of Parent or Guardian*

\_\_\_\_\_  
*Date*



As a parent of \_\_\_\_\_, I attest that these services are not provided in the private school of my child's attendance.

*Signature* \_\_\_\_\_

*Date* \_\_\_\_\_



**RETURN FORM TO: Office of Stanwood-Camano School District Superintendent**  
Action: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Reviewed by: _____ Staff Signature	Date: _____
Is there an accompanying signed Certificate of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	



DOH 348-013  
Rev: 10/15/08

# Certificate of Immunization Status (CIS)

Child's Last Name:	First Name:	Middle Initial:	Child's Address:
Child's Birthdate:		Child's Sex:	
Parent/Guardian Name:		Parent/Guardian Day Phone:	

If completing by hand, write the vaccine in the row to the left of "Dose" and the date the vaccine was received in the "Date" column. Age column is optional.

◆ Required for School and Child Care/Preschool   ● Required for Child Care/Preschool Only

Vaccine	Dose	Date	Age	Vaccine	Dose	Date	Age	Vaccine	Dose	Date	Age
<b>◆ Hepatitis B (Hep B)</b>				<b>● Pneumococcal (PCV, PPV)</b>				<b>Hepatitis A (Hep A)</b>			
	1				1				1		
	2				2				2		
	3				3						
	4				4						
<b>Hepatitis B (Hep B) Alternate schedule for teens</b>				<b>◆ Polio (IPV, OPV)</b>				<b>Meningococcal (MCV4, MPSV4)</b>			
	1				1				1		
	2				2						
<b>Rotavirus</b>				<b>Influenza (most recent)</b>				<b>Human Papillomavirus (HPV)</b>			
	1				1				1		
	2				2				2		
	3				3				3		
	4				4						
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>				<b>◆ Measles, Mumps, Rubella (MMR)</b>				<b>Other</b>			
	1				1						
	2				2						
	3										
	4										
	5										
<b>◆ Diphtheria, Tetanus, Pertussis (Tdap, Td)</b>				<b>◆ Varicella (chickenpox)</b>				<div style="border: 2px solid black; padding: 10px; margin-bottom: 5px;"> <b>I certify that the information provided here is correct and verifiable.</b> </div> <hr/> Signature of Parent or Guardian _____ Date _____			
	1				1						
	2				2						
<b>● Haemophilus influenzae type b (Hib)</b>					1						
	1				2						
	2			<b>▼ Verification of varicella disease history ▼</b>				<b>Licensed HCP Signature (MD, DO, ND, PA, ARNP) _____ Date _____</b>			
	3			<input type="checkbox"/> Health Care Provider (HCP) Verified ▶	<input type="checkbox"/> Signed note from HCP attached or <input type="checkbox"/> HCP provider signature here: ▶			<b>Either initial with parent approval or get parent signature below:</b> Staff initials indicating parent approval: _____ Parent Signature indicating approval: _____			
	4			<input type="checkbox"/> HCP Verified by Registry ▶	No HCP Sig required if box at left checked. <b>If school staff find verification in the Registry, then school staff must: ▶</b>						
See the back of this page for documentation of immunity, a vaccine trade name reference guide, and a vaccine abbreviation list.				<input type="checkbox"/> Parental Report ▶	<b>ONLY</b> acceptable for some grades. Write date or age child had disease.						

## Documentation of Immunity by Blood Test (titer)

I certify that the child named on this form has laboratory evidence of immunity to (check all that apply):

- Diphtheria   
  Hepatitis A   
  Hepatitis B   
  Hib   
  Measles   
  Mumps   
  Polio   
  Rubella   
  Tetanus   
  Varicella  
 Other (list): \_\_\_\_\_  lab report(s) attached (required)

X  
 Typed or Printed Name of **Licensed Health Care Provider** (MD, DO, ND, PA, ARNP)

X  
 Signature of **Licensed Health Care Provider** (required) Date (required)

### Vaccine Trade Names\*

Read down and across - Trade Names are in Alphabetical Order.

Trade Name	Vaccine	Trade Name	Vaccine
Acel-Imune	DTaP	Menomune	MPSV4
ActHIB	Hib	OmniHIB	Hib
Adacel	Tdap	Pediarix	DTaP + IPV + Hep B
Boostrix	Tdap	PedvaxHIB	Hib
Certiva	HPV	Pentacel	DTaP + IPV + Hib
Comvax	Hib + Hep B	Pentavalente	DTaP + Hep B + Hib
Daptacel	DTaP	Pneumovax	PPV23
Decavac	Td	Prevnar	PCV or PCV7
Engerix-B	Hep B	ProHIBit	Hib
Fluarix	Flu	ProQuad	MMRV
FluMist	Flu	Quadracel	DTaP + IPV
Fluvirin	Flu	Recombivax	Hep B
Fluzone	Flu	Rotarix	Rotavirus
Gardasil	HPV	RotaTeq	Rotavirus
Havrix	Hep A	Tetramune	DTP + Hib
HibTITER	Hib	TriHIBit	DTaP + Hib
HyperTET	TIG	Tri-Immunol	DTP
HyperHEP B	HBIG	Tripedia	DTaP
Ipol	IPV	Twinrix	Hep B + Hep A
Infanrix	DTaP	Vaqa	Hep A
Kinrix	DTaP + IPV	Varivax	Varicella
Menactra	MCV4		

### Vaccine Abbreviations\*

Read down - Abbreviations are in Alphabetical Order.

Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus
DTaP	Diphtheria, Tetanus, acellular Pertussis
DTP	Diphtheria, Tetanus, Pertussis
Flu (TIV or LAIV)	Influenza
HBIG	Hepatitis B Immune Globulin
Hep A (HAV)	Hepatitis A
Hep B (HBV)	Hepatitis B
Hib	<i>Haemophilus influenzae</i> type b
HPV	Human Papillomavirus
IPV	Inactivated Poliovirus Vaccine
MCV4	Meningococcal Conjugate Vaccine
MPSV4	Meningococcal Polysaccharide Vaccine
MMR	Measles, Mumps, Rubella
MMRV	Measles, Mumps, Rubella, Varicella
OPV	Oral Poliovirus vaccine
PCV or PCV7	Pneumococcal Conjugate Vaccine
PPV23	Pneumococcal Polysaccharide Vaccine
Rota (RV1 or RV5)	Rotavirus
Td	Tetanus, Diphtheria
Tdap	Tetanus, Diphtheria, acellular Pertussis
TIG	Tetanus immune globulin
VAR or VZV	Varicella

\*These lists may not be comprehensive; visit <http://www.doh.wa.gov/cfh/immunize/forms/default.htm> for updated lists.

# Certificate of Exemption (COE)

From School, Child Care and Preschool Immunization Requirements<sup>1</sup>



DOH 348-106 Revised: 10/15/08

Child's Last Name:	First Name:	Middle Initial:	Child's Address:
Child's Birthdate:	Child's Sex:		
Parent/Guardian Name:			Parent/Guardian Day Phone:

Please choose the exemption(s) that apply to your child as listed below.

Temporary Medical Exemption

Permanent Medical Exemption

I certify that the child named on this form is medically exempted from the requirement for the following vaccine(s):

\_\_\_\_\_  
Vaccine(s) Until Date (or Perm.)

X  
Type or Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X  
Signature of Licensed Health Care Provider Date

Personal/Philosophical Exemption

Religious Exemption

I do not want my child to get the following vaccine(s).

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Diphtheria   | <input type="checkbox"/> Hepatitis B            | <input type="checkbox"/> Hib                        |
| <input type="checkbox"/> Measles      | <input type="checkbox"/> Mumps                  | <input type="checkbox"/> Pertussis (whooping cough) |
| <input type="checkbox"/> Pneumococcal | <input type="checkbox"/> Polio                  | <input type="checkbox"/> Rubella                    |
| <input type="checkbox"/> Tetanus      | <input type="checkbox"/> Varicella (chickenpox) |   |

Other (indicate):  
\_\_\_\_\_  
\_\_\_\_\_

**Parent/Guardian Notice:** "I certify that the information provided here is correct and verifiable. I understand that if there is an outbreak of a vaccine-preventable disease my child has not been fully immunized against (as indicated above, for medical, personal/philosophical or religious reasons), my child may be at risk for disease and can be **excluded** from school, child care or preschool until the outbreak is over."

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

<sup>1</sup> RCW 28A.210.080-090 state that before or on the first day of every child's attendance at any public and private school or licensed day care center in Washington State 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. Medical exemptions must be signed by a licensed health care provider.