

# The South Whidbey Children's Center

## Identification and Emergency Information Sheet

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

### For School Aged Children

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City and Zip : \_\_\_\_\_

Mailing address if different: \_\_\_\_\_

How would you like to receive your newsletters? Please check one: email \_\_\_\_\_ paper \_\_\_\_\_

Include in the SWCC Family Directory? Please check one: yes \_\_\_\_\_ no \_\_\_\_\_

How did you hear about SWCC? \_\_\_\_\_

### Mother/Legal Guardian

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer-Name of Company: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Schedule: \_\_\_\_\_

Email: \_\_\_\_\_

### Father/Legal Guardian

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer-Name of Company: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Schedule: \_\_\_\_\_

Email: \_\_\_\_\_

Child lives with: both parents \_\_\_\_\_ mother only \_\_\_\_\_ father only \_\_\_\_\_

Does the adult that the child lives with have legal custody? yes \_\_\_\_\_ no \_\_\_\_\_

Siblings (name and age/s): \_\_\_\_\_

Others living in the household: \_\_\_\_\_

Child's ethnicity for US Census and Educational Grants (optional)

\_\_\_\_\_Caucasian \_\_\_\_\_Asian \_\_\_\_\_African American \_\_\_\_\_Native American \_\_\_\_\_Latin American

\_\_\_\_\_Other \_\_\_\_\_

What is your preferred language for information sharing? \_\_\_\_\_

### Emergency Information

Persons to be called in case of an **emergency** and who are **authorized to pick-up child**.

Your child will only be released to individuals listed. Be sure to include names of both parents if applicable.

Name	Address	Home Phone	Work phone	Relationship to child

## Medical Information

Child's physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Date of last check up:** \_\_\_\_\_ **(do not leave blank)**

Child's dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

**Date of last dental check up:** \_\_\_\_\_ **(do not leave blank)**

Emergency Hospital preference(**not closest**): \_\_\_\_\_

Address: \_\_\_\_\_

Known medical conditions and daily medications: \_\_\_\_\_

Known allergies, including food allergies: \_\_\_\_\_

Dietary restrictions/sensitivities: \_\_\_\_\_

Special needs or developmental concerns: \_\_\_\_\_

Does your child have a current IEP or IFSP? yes \_\_\_\_\_ no \_\_\_\_\_

## Home and Family Life

(please answer in detail so that we can better care for your child)

Information you would like for us to know about your child: \_\_\_\_\_

Describe any learning programs, schools or playgroups in which your child was involved?

What are your child's favorite toys, games or activities? \_\_\_\_\_

What foods does your child especially like? \_\_\_\_\_  
dislike? \_\_\_\_\_

What time are family meals generally served? \_\_\_\_\_

Does your child have a pet? \_\_\_\_\_

How does your child express anger and/or frustration? \_\_\_\_\_

Does your child have any special fears? \_\_\_\_\_

When your child is upset, what works best to comfort him/her? \_\_\_\_\_

How do you discipline your child? \_\_\_\_\_

Does your family have any special traditions that you would like for us to know about? \_\_\_\_\_

Is there anything else you would like for us to know about your child or family that might help us in caring for your child? \_\_\_\_\_

Teachers Name: _____	Room Number: _____
Grade in School: _____	Bus Route: _____

I give permission for SWCC to share my child's information with appropriate teaching staff and regulatory authorities.

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

***Please return this packet and the \$60.00 registration fee prior to your child's first day of attendance.***

**South Whidbey Children's Center  
Field Trip Release Form**

My child \_\_\_\_\_ is hereby granted permission to take field trips, organized as part of the program at South Whidbey Children's Center.

It is my understanding that the staff will take every reasonable precaution for the safety of my child. It is further my understanding that proper and sufficient supervision will be provided by the staff of the Children's Center at all times.

Therefore, the South Whidbey Children's Center and its staff members accompanying the children on the field trips are **released** from any liability in the event any liabilities result from action of my child while on a field trip.

Date: \_\_\_\_\_

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

Special Instructions: \_\_\_\_\_

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\*\*\*\*\*

**NO**, I do not wish my child to take part in any field trips:

Date: \_\_\_\_\_

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

\*\*\*\*\*

**NOTE:** State Regulations require that when children are transported in private vehicles, they **must** ride in a car seat when the child is 1-4 years or a booster seat when the child is 4-8 years old and under 4'9" .

The South Whidbey Children's Center policies require that when children are escorted off premises on foot, they **must** hold hands.

## South Whidbey Children's Center Consent For Emergency Treatment

I hereby give permission for my child \_\_\_\_\_ to be given emergency treatment by a qualified staff member of the South Whidbey Children's Center.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

In the event that I cannot be contacted, I further consent to the 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.

Child's Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Preferred Hospital(not closest): \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

ID #: \_\_\_\_\_

Date of Last Tetanus (or DPT) Immunization: \_\_\_\_\_

Allergies (Drug or Other): \_\_\_\_\_

\_\_\_\_\_

Mother's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

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

South Whidbey Children's Center  
**Schedule Form**

SIGN-UP (starting) FOR THE MONTH OF \_\_\_\_\_ 20\_\_

Name of parent(s)/guardian(s): \_\_\_\_\_

Name of child: \_\_\_\_\_

Please indicate the hours you plan to have your child attend and the hours you plan to pick him/her up:

	Check day attending & Write down drop off time	Pick-up Time
MONDAY	_____	_____
TUESDAY	_____	_____
WEDNESDAY	_____	_____
THURSDAY	_____	_____
FRIDAY	_____	_____

Comments:

## Photo Release

At the South Whidbey Children's Center we like to use pictures of children for our display boards, website, and sometimes in newspaper articles (i.e. 4<sup>th</sup> of July Parade.) We would love to be able to use photos with your children and family. Please let us know that we have your permission to share these photos by signing below.

Child's or Children's Name(s):

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I certify that I am a custodial parent and have the aforementioned rights to assign.

Signature of  
Parent or Guardian:

---

Print Name of  
Parent or Guardian:

---

Date: \_\_\_\_\_

---

I do not want my child's photo and/or other digital reproduction of him/her or other reproduction of his/her physical likeness used for any purpose.

Child's or Children's Name(s):

---

I certify that I am a custodial parent and have the aforementioned rights to assign.

Signature of  
Parent or Guardian:

---

Print Name of  
Parent or Guardian:

---

Date: \_\_\_\_\_

## Family Volunteers

The South Whidbey Children's Center makes every effort to reduce tuition costs while continuing to provide the highest standards in care. In order to accomplish those goals, we hold annual fundraisers and quarterly school work parties. We expect that all families will volunteer time to the school.

There are many ways to contribute to the school, and all of them show your children that you value their school, teachers and how they spend their days. Each classroom has a room parent, and the room parent sends out informational emails regarding ways to be involved. You can take home a bin of toys to sanitize, come in a little early and clean rest mats, sweep the bike path or read books to the children. No gesture is too small and the teachers really appreciate the help. We also like to have one family per room recognize their classroom teachers each month for teacher appreciation. You can sign up through your room parent. Some great ideas that have happened in the past are, baking cookies or brownies, writing each teacher a card, flowers, plants or bringing in lunch for the teachers. It might be something small- but it goes a long way to show the teachers that you appreciate their hard work.

You can sign up to come to a quarterly work party. On these days we come together to pull weeds, paint and make repairs to equipment and deep clean the rooms. We always need extra hands on these days and it is amazing how much work we can get done!

You might want to help out with fundraising. Each year we hold several fundraising events. Around February we put out an annual giving letter, in late Spring we have a raffle and need parents to sign up and sell tickets at the local farmer's markets, in the summer we hold our big annual fundraising event and we need all sorts of help to pull that one off. As we move into the fall we end the year with our annual button people/craft fair and coffee selling fundraiser. If you are crafty, we need items to sell and have regular get-togethers to make items for the sale.

With so many interesting ways to be involved, hopefully one will work your family and schedule. If you want to be involved on a regular basis as a volunteer in the classroom, please see Kris and she can tell you how to register with the Department of Early Learning.

As always we really appreciate your help and continued support.

Thank you,

Kris Barker  
Executive Director

**PLEASE REVIEW HANDBOOK, SIGN AND RETURN**  
**South Whidbey Children's Center Service Agreement**

Initials:

\_\_\_\_\_ 1. Fees: Tuition and DSHS Co-Pay is due by the 10<sup>th</sup> of every month. I understand that if I am unable to pay by this time, I need to make arrangements with the Director. The SWCC accepts cash, checks, and credit cards.

\_\_\_\_\_ 2. I understand and will pay the \$20 per month materials fee per family.

\_\_\_\_\_ 3. Signing In/Out: I understand that I must sign in and out each day with my **full signature**. This is how I transfer responsibility for my child to and from the Children's Center.

\_\_\_\_\_ 4. I have read and understand the Center's challenging behavior policy.

\_\_\_\_\_ 5. Late Pick Up: I understand that pick up time for the morning session is 1:00 pm, and for afternoon or full day, pick up time is 5:30 pm. I will be charged a late pick up fee for any time that extends beyond 15 minutes late. Late pick up from our morning session will be billed at the whole day rate, and pick up past 5:45 will be billed at \$1 per minute, with a minimum of \$15.

\_\_\_\_\_ 6. Vacations: The preschool operates on a year round basis; therefore I will be billed at the same rate each month regardless of missed time. The School-Aged Program is based on a 180 day school schedule and I will be billed at the same rate in December, April, and June. Non-school days are billed at our whole or half day rate. For School Age summer care only, if I notify the office staff of our summer vacation schedule two weeks in advance, fees will be prorated.

\_\_\_\_\_ 7. Illnesses: I know that my child must be at the very minimum: fever, vomit, and diarrhea free for at least **24 hours** before my child can attend the Children's Center and that if my child is unable to fully participate in the day's activities, he/she will be sent home.

\_\_\_\_\_ 8. Withdrawal or Schedule Reduction: I understand that if I need to withdraw my child from the Children's Center or reduce the number of days attending per week, I will give two weeks written notice and will be billed for that time.

\_\_\_\_\_ 9. I have read and understand SWCC's family volunteer expectations.

\_\_\_\_\_ 10. I have read and understand SWCC's pet policy.

***I have read and agree to all of the Children's Center Policies:***

\_\_\_\_\_  
Parent or Guardian Signature                      Date                      Print Name

\_\_\_\_\_  
Parent or Guardian Signature                      Date                      Print Name

\_\_\_\_\_  
Director Signature                      Date





## South Whidbey Children's Center School Age 2018-19 Monthly Fee Schedule

Our Before and After School program offers many options for families. Once registered you can have a set schedule or drop in with 24 hour advance notice. It is more economical to have a set schedule. Our fees are based on the school year/district 180 day calendar. If you have a set schedule we additionally bill full price for non-school days and \$7.00 for early release Wednesdays. We have an annual registration fee of \$60.00 per child and tuition will be increased 3-5% annually for a cost of living adjustment. **We require 2 week notice for schedule changes or to discontinue service and 1 week notice to cancel an added day.**

### Before/After School Age Program-monthly fees (Kindergarten thru Fifth grade)

#### Before School

1 morning per week	\$68.00
2 mornings per week	\$136.00
3 mornings per week	\$204.00
4 mornings per week	\$272.00
5 mornings per week	\$340.00

#### After School

1 afternoon per week	\$68.00
2 afternoons per week	\$136.00
3 afternoons per week	\$204.00
4 afternoons per week	\$272.00
5 afternoons per week	\$340.00

#### Combined Before and After

1 morning/afternoon per week	\$133.00
2 mornings/afternoons per week	\$266.00
3 mornings/afternoons per week	\$399.00
4 mornings/afternoons per week	\$533.00
5 mornings/afternoons per week	\$665.00

Daily add on rate/drop in rate (24 hour notice) \$16.50

**The School Age program is open from 6:30 am until bus pick up at 8:30 am and 3:30 until 5:30 pm Monday through Friday.**

### Holiday/Early Release and School Age Summer Camp Program (Kindergarten thru Fifth grade)

1 day	\$50.00
1 half day morning	\$34.00
1 half day afternoon	\$34.00(half day early release or non-school day)
1	2:00 pm early release \$25.00(non-scheduled day with 24hour notice)
1	2:00 pm early release \$7.00 (scheduled day)

**On non-school days we are open 6:30 am until 5:30 pm.**

**Morning hours are anytime between 6:30 and 12:30 pm. Afternoon hours are from 12:30 PM to 5:30 pm. Children cannot be in care for over 10 hours on any one day.**

**Late fees will be charged for children picked up after closing.**



## AUTHORIZATION FOR EXCHANGE OF INFORMATION

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

I hereby authorize the exchange of information between South Whidbey Children's Center and:

Agency/Practitioner/School District: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Effective Dates: \_\_\_\_\_

Comments: \_\_\_\_\_

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

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

\_\_\_\_\_  
Date

Please send all information to: South Whidbey Children's Center  
120 Sixth Street  
Langley, WA 98260  
swcc.director@whidbey.com

## OPTIONAL

### Automatic Payment From Your Credit/Debit Card

#### TERMS OF AGREEMENT

I am authorizing the [SOUTH WHIDBEY CHILDREN'S CENTER](#) to charge my credit/debit card account monthly for my child's tuition and any extra days billed for the preceding month. I understand that I will be billed a fee of \$35.00 per year to use this service.

This agreement will remain in effect until I have given at least thirty (30) days written notice of its termination. A record of each payment will appear on my credit card statement and will serve as my receipt.

#### Credit Card:

VISA

MasterCard

#### Please complete the following information:

Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Credit card #: \_\_\_\_\_

Security code #(3 digit # on back of card) \_\_\_\_\_

Expiration date: \_\_\_\_\_

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

Date: \_\_\_\_\_

Credit Card information will be entered into a password protected computer file.



## Sunscreen Authorization Form (Sunscreen Brought from Home)

<b>Child's Name:</b>	<b>Date of Birth &amp; Age:</b>  <small>(Do not apply on infants 6 months and younger without written permission from health care provider)</small>
<b>Name of Sunscreen &amp; SPF:</b>	<b>Active Ingredients:</b>
<b>Start Date:</b>	<b>Stop Date: (up to 6 mo. after 'start date')</b>
<b>Times to be Applied:</b>	<b>Possible Side Effects:</b>
<b>Special Instructions: (Include previous sunscreen reactions)</b>	

**Reason for medication:** Protection from sun  
**Amount to be given:** Cover exposed areas of skin  
**Route:** Topical  
**Storage:** Room temperature

\_\_\_\_\_  
**Parent/Guardian Signature**

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

\_\_\_\_\_  
**Daytime Phone Number**



# Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

<b>Office Use Only:</b>	
Reviewed by: _____	Date: _____
Signed Cert. of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

<b>Child's Last Name:</b> _____	<b>First Name:</b> _____	<b>Middle Initial:</b> _____	<b>Birthdate (mm/dd/yyyy):</b> _____	<b>Sex:</b> _____	<b>I certify that the information provided on this form is correct and verifiable.</b>
Symbols below: ◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only				<b>Parent/Guardian Name (please print):</b> _____	

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Hepatitis B (Hep B)</b>				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
<b>Rotavirus (RV1, RV5)</b>				
	1			
	2			
	3			
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>				
	1			
	2			
	3			
	4			
	5			
<b>◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)</b>				
	1			
	2			
<b>● Haemophilus influenzae type b (Hib)</b>				
	1			
	2			
	3			
	4			
<b>● Pneumococcal (PCV, PPSV)</b>				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Polio (IPV, OPV)</b>				
	1			
	2			
	3			
	4			
<b>Influenza (flu, most recent)</b>				
<b>◆ Measles, Mumps, Rubella (MMR)</b>				
	1			
	2			
<b>◆ Varicella (chickenpox) or verify disease 1-4 ▶</b>				
	1			
	2			
<b>Hepatitis A (Hep A)</b>				
	1			
	2			
<b>Meningococcal (MCV, MPSV)</b>				
	1			
<b>Human Papillomavirus (HPV)</b>				
	1			
	2			
	3			
<b>Office Use Only: Immunization information updated and verified with parent/guardian permission:</b>				
Printed Staff Name	Date	Printed Staff Name	Date	
Printed Staff Name	Date	Printed Staff Name	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.**

<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 health care provider (HCP) Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)  
 HCP Printed Name: \_\_\_\_\_

# Certificate of Exemption

**SIDE A:**  
For Religious, Personal,  
Philosophical, and Medical  
Exemptions<sup>1</sup>

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

<sup>1</sup>RCW 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

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

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

<sup>1</sup>RCW 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."

FIRST NAME

M.I.

**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 CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD 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 CHILD 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**

**#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 ▶

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>				
DTaP	<b>1</b>	01	12	2011
DTaP	<b>2</b>	03	20	2011
DTaP	<b>3</b>	06	01	2011

**#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 CHILD 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 CHILD 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/cfh/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 <a href="http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf">http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf</a> )									
Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menaetra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqa	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrel)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

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

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