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? ❑ Yes ❑ 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
◆ **Hepatitis B (Hep B)**			
	1		
	2		
	3		
Hepatitis B (Hep B) Alternate schedule for teens			
	1		
	2		
Rotavirus			
	1		
	2		
	3		
◆ **Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)**			
	1		
	2		
	3		
	4		
	5		
◆ **Diphtheria, Tetanus, Pertussis (Tdap, Td)**			
	1		
	2		
● ***Haemophilus influenzae* type b (Hib)**			
	1		
	2		
	3		
	4		

Vaccine	Dose	Date	Age
● **Pneumococcal (PCV, PPV)**			
	1		
	2		
	3		
	4		
◆ **Polio (IPV, OPV)**			
	1		
	2		
	3		
	4		
Influenza (most recent)			
◆ **Measles, Mumps, Rubella (MMR)**			
	1		
	2		
◆ **Varicella (chickenpox)**			
	1		
	2		

Vaccine	Dose	Date	Age
Hepatitis A (Hep A)			
	1		
	2		
Meningococcal (MCV4, MPSV4)			
	1		
Human Papillomavirus (HPV)			
	1		
	2		
	3		
Other			

See the back of this page for documentation of immunity, a vaccine trade name reference guide, and a vaccine abbreviation list.

I certify that the information provided here is correct and verifiable.

Signature of Parent or Guardian Date

Licensed HCP Signature (MD, DO, ND, PA, ARNP) **Date**

▼ **Verification of varicella disease history** ▼

❑ Health Care Provider (HCP) Verified ▶	❑ Signed note from HCP attached **or** ❑ HCP provider signature here: ▶	
❑ HCP Verified by Registry ▶	No HCP Sig required if box at left checked.	**If school staff find verification in the Registry, then school staff must:** ▶ **Either** initial with parent approval or get parent signature below: Staff initials indicating parent approval:
❑ Parental Report ▶	**ONLY** acceptable for some grades. Write date or age child had disease:	Parent Signature indicating approval:

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	Heb 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	Vaqta	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	*Haemophilus influenzae* 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.** **DOH 348-013 Revised: 10/15/08**

Certificate of Exemption (COE)

From School, Child Care and Preschool Immunization Requirements[1]

Washington State Department of Health

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).

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

[1] 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.