Office Use Only:			
Enrollment Date:		Withdrawal Date:	

MONTESSORI PRESCHOOL ADMISSION APPLICATION

2025-2026

Please return the following forms and $250 per child registration fee to the school office.

Application Date: _____

Please check one:

☐ AM Half Day Program (8:30 a.m. – 11:30 a.m.) ☐ Full Day Program (8:30 a.m. – 2:50 p.m.)

Student #1 Information

Student Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Date of Birth: _____ Gender: ☐M / ☐F Current Age: _____
YEARS MONTHS

Baptized ☐Yes /☐No (If yes, please provide copy of Baptismal Certificate) Church: _____

Does student have current sibling(s) at CKCS? ☐Yes ☐No

Do you plan on sending your student to Christ the King Catholic School K-8 ☐Yes ☐ No

Who were you referred by:

Primary Address: _____
STREET CITY STATE ZIP

Religion: _____ Registered in Catholic Parish ☐Yes / ☐ No Parish: _____

Ethnicity: (Optional) ☐Caucasian ☐African American ☐ Hispanic ☐Multiracial ☐Native American ☐Asian

☐Father ☐Stepfather ☐Guardian

Name:

Address: ☐ Same as Above

STREET

CITY STATE ZIP

Cell Phone:

Home Phone:

Work Phone:

Primary Email:

Occupation:

Employer:

Status: ☐Married ☐Single ☐Divorced ☐Deceased

☐Mother ☐Stepmother ☐Guardian

Name:

Address: ☐ Same as Above

STREET

CITY STATE ZIP

Cell Phone:

Home Phone:

Work Phone:

Primary Email:

Occupation:

Employer:

Status: ☐Married ☐Single ☐Divorced ☐Deceased

Student(s) live with:

☐ Both Parents ☐ Mother only ☐ Father only ☐ Mother & Stepfather ☐ Father & Stepmother

Other: (Please specify)

If applicable: ***(Custodial Adults): Please provide a copy of the court custodial document for our records.***

I, _____ , have full custody of the children named above.

We _____ and _____ have joint custody.

Emergency and Pick Up Contacts (must be other than parents)

1. _____ ☐Emergency ☐ Pick Up
   FIRST NAME LAST NAME RELATIONSHIP PHONE NUMBER
2. _____ ☐Emergency ☐ Pick Up
   FIRST NAME LAST NAME RELATIONSHIP PHONE NUMBER
3. _____ ☐Emergency ☐ Pick Up
   FIRST NAME LAST NAME RELATIONSHIP PHONE NUMBER
4. _____ ☐Emergency ☐ Pick Up
   FIRST NAME LAST NAME RELATIONSHIP PHONE NUMBER

I give permission for any person above to be contacted and for my child(ren) to be released to those listed as pick up.

Parent or Legal Guardian Signature: _____ Date: _____

Date Received:	Check #:	Cash:	Initials

ENROLLMENT CONTRACT
2025-2026

Tuition **Family Name**

Tuition is due on the first of each month, **September 2025 – June 2026**, and it past due unless it is received by the 10th of the month. **Tuition received after the 10th of the month will be subject to a $20 late fee.** Tuition that is over 30 days delinquent may be charged an additional 1.5% on the total tuition balance. **Tuition is prorated based on 163 days of school.**

Half Day AM		Full Day Program	
Registration (Non-Refundable)	$250.00	Registration (Non-Refundable)	$250.00
Tuition	$4,790.00	Tuition	$9,090.00

☐ I am a CK Parishioner, and I would like to apply for financial aid

Tuition Guidelines:

1) All registration payments will be made directly to Christ the King Catholic School since school finances are separate from parish finances.
2) **Once you have been accepted Registration fees are non-refundable.** Registration fees equal to one child are due at the time of initial registration. Multi-student families, registration fees may be made in payments equaling one child per month.
3) Tuition is paid on a ten-month schedule from September – June. ACH is strongly encouraged (see attached form). If you are unable to do ACH, arrangements can be made through the finance office.
4) Family accounts will be assessed a $25 return check fee on checks returned for non-sufficient funds.
5) Families must be up to date on all accounts before they can register their children for the following year.
6) Families who fall one month behind in their payments will be notified that their payments are late. Families who fall two months behind in their payments will be notified again at the end of the second delinquent month. Their children will no longer be enrolled in the Montessori program if payment is not received by the designated date.
7) Any questions concerning the tuition plan should be referred to the Director of the Montessori Preschool, Kelly Buchanan or Usa Sondag in the Christ the King School Finance Office. (509) 946-6158 or usondag@ckschool.net.
8) Any family including those receiving financial aid falls behind in payments, the following may result (A) The scholarship amount will be withdrawn; (B) My child(ren) may be withdrawn from Christ the King Catholic School.

I have read the Enrollment Contract and I understand that I have a moral and legal obligation to fulfill my responsibilities. I further understand that failure to comply with the payment schedule outlined in the tuition payment plan may result in: (A) My child(ren) will be withdrawn from Christ the King School; (B) Initiation of legal proceedings; (C) Loss of eligibility for re-registering; (D) subject to Collection Agency.

Parent or Legal Guardian (Printed Name): _____

Parent or Legal Guardian Signature: _____ Date: _____

CHRIST THE KING CATHOLIC SCHOOL encourages ACH withdrawals as the primary means of payment for ***regular monthly tuition and cafeteria payments***.

**** A new form is required each year to authorize the new Tuition amounts ****

DIRECT PAYMENT Authorization Form 2025-2026

Student Family Last Name _____

I hereby authorize **Christ the King Catholic School** to initiate withdrawals from my account at the financial institution named in this application for payment of my **regular monthly** bills to Christ the King Catholic School. This authorization will remain valid until **June 30, 2026**, or until either I, Christ the King Catholic School, or my financial institution revoke it.

Monthly K-8 Tuition:	$_____	Monthly Pre-School Tuition:	$_____
Monthly Cafeteria:	$_____	Before & After School Care:	$_____
General Fees	$_____	Registration Fee:	$_____

I understand that the Direct Payment program is an alternative method of payment only and does not otherwise affect my rights or the rights of Christ the King Catholic School or my financial institution with respect to each other. I further understand that Christ the King Catholic School and my financial institution reserve the right to terminate the Direct Payment plan and/or my participation in it.

This authority is to remain in full force and effect until Christ the King School has received written notification from me (or either of us) of its termination in such time and manner as to afford Christ the King Catholic School and the financial institution a reasonable opportunity to act on it.

Name of Financial Institution	Checking or Savings	Bank Routing Number	Bank Account Number

Indicate date of monthly ACH withdrawal:

1st of each month: $ _____, starting _____
10th of each month: $_____, starting _____
15th of each month* $_____, starting _____

Note: Family accounts will be assessed a $25.00 fee on return ACH for non-sufficient funds. ***$20.00** late fee will be charged to family accounts for NSF-15th ACH no exceptions.

Account Holder Signature Date

Joint Account Holder Signature Date

For Christ the King Catholic School to verify bank account and routing numbers, account holders should attach a **VOIDED CHECK** for the account holder account that is to be debited. Christ the King Catholic School and account holders should retain completed copies of this form for their records.

Place VOIDED CHECK Here

FACTS SIS ParentsWeb
REGISTRATION INSTRUCTIONS

FACTS SIS ParentsWeb is a private and secure parents' portal that will allow parents to view academic information specific to their children, while protecting their children's information from others. You can see your child's grades, attendance, homework, conduct, and school directory as well as other useful school information. You can also communicate with teachers and other school staff online whenever necessary. All you need is an Internet-capable computer.

Here's how to access our easy-to-us FACTS SIS ParentsWeb:

- Turn in your FACTS SIS registration form with your admission packet. The email addresses you put on this form will be the ones you use to set up your ParentsWeb account.
- Next, go to www.renweb.com and click Logins.
- Click ParentsWeb Login.
- Type your school's **District Code CK-WA**
- Click Create New ParentsWeb Account.
- Type your email address and an email is sent to you.
- Click the Click to change password link. This link is only valid for 30 minutes.
- A web browser displays your Name and RenWeb ID.
- Type a Username, Password and confirm the password.
- Click Save Password. A message will display "Username/Password successfully updated."
- You can now log into ParentsWeb using your new username and password.

RenWeb ParentsWeb
DIRECTORY REGISTRATION AND WAIVER

Student Name #1: _____ Grade: _____ 2025-2026

Student Name #2: _____ Grade: _____ 2025-2026

Student Name #3: _____ Grade: _____ 2025-2026

Student Name #4: _____ Grade: _____ 2025-2026

Parent/Guardian Information:

Father's Name: _____ Email: _____

Mother's Name: _____ Email: _____

Student Lives with:

☐ Both Parents ☐ Mother only ☐ Father only ☐ Mother & Stepfather ☐ Father & Stepmother

Directory Information: *The school defines "directory information" as the student's name, birth date, grade level, family members' names, addresses, emails and phone numbers. This information is available on the FACTS – a private and secure parents' portal. It is understood that the school is free to allow access to school staff, church staff, families.*

☐ **I DO NOT WANT MY DIRECTORY INFORMATION RELEASED**

Media, Video & Photo: Photos or videos of students may be used in the FACTS Family Portal (Parentsweb), the school website, public social media groups or pages, school publicity or emails unless parents prohibit as indicated by checking the box below.

☐ **I DO NOT WANT PHOTOS AND/OR VIDEOS WITH MY CHILD(REN)'S INCLUDED POSTED ON THE FACTS FAMILY PORTAL (PARENTSWEB), SCHOOL WEBSITE, SOCIAL MEDIA, SCHOOL PUBLICITY OR EMAILS.**

Parent or Legal Guardian Signature: _____ Date: _____

CHILDCARE CENTER VACCINATION POLICY

At Christ the King Montessori Preschool, we prioritize the health and safety of all children, staff, and families. In compliance with the Washington Administrative Code (WAC) WAC number 246-105-030 requires that all children enrolled in our center are vaccinated according to the immunization schedule recommended by the Washington State Department of Health.

Key Policy Points:

1. **Proof of Immunization:**
   - Parents/guardians **must** provide a completed and up-to-date Certificate of Immunization Status (CIS) form before a child's first day of attendance.
   - The CIS must reflect compliance with required vaccinations or document a medically verified exemption.
2. **Exemptions:**
   - **Only** medically verified exemptions, signed by a licensed healthcare provider, will be accepted, as per WAC guidelines. Personal or philosophical exemptions are not permitted for the MMR (measles, mumps, rubella) vaccine.
3. **Record Updates:**
   - Families are responsible for updating immunization records whenever new vaccines are administered.
   - Periodic reviews of immunization compliance will be conducted, and families will be notified if updates are needed.
4. **Non-Compliance:**
   - Children who are not in compliance with the WAC immunization requirements will not be allowed to attend the childcare center until proper documentation is provided.

Additional Information:

For more details on immunization requirements and schedules, visit the Washington State Department of Health website at https://doh.wa.gov/you-and-your-family/immunization

This policy ensures we maintain a safe and healthy environment for all. Thank you for your cooperation.

Christ the King Vaccination Policy

Personal or philosophical exemptions are no longer allowed under Washington State Law for the Measles, Mumps and Rubella vaccines (MMR).

Additionally, tied to the Catholic Church's teachings uplifting the "common good", **the Diocese of Yakima will not allow exemptions based on religious affiliation, personal or philosophical reasons for any of the eleven required childhood vaccines:**

• Chickenpox (Varicella)

• Diphtheria • German measles (Rubella)

• Haemophilus influenzae type b (Hib) *

• Hepatitis B • Pertussis • Pneumococcal *

• Tetanus • Measles • Mumps • Polio (Poliomyelitis)

(* Required for children under 5 years of age.)

All students attending Yakima diocesan schools must provide a proof of vaccination, or have a measurable schedule consistent with ACIP guidelines for timing of vaccination in place prior to enrollment. This applies to all the immunizations listed above.

Should a student apply to be enrolled with a medical exemption as defined by law in the Washington State RCW, the application and associated medical information will be forwarded to the Vice-Chancellor of the Diocese of Yakima for a review.

Medical exemptions require a medical diagnosis that the Diocese of Yakima and its medical personnel can review. **A note from a physician is not sufficient.**

In the circumstance where a medical exemption is granted by the Diocese of Yakima, additional requirements will be placed upon the medically exempt, or partially-vaccinated student should a local disease outbreak occur. For example, the student might be required to stay home and learn remotely during, and immediately after, the outbreak.

Updated February 2025

STUDENT HEALTH HISTORY FORM

(An individual care plan from your child's health care provider is required for any food allergies, special dietary requirements due to a health condition and/or special needs.)

This information is considered confidential. To ensure the health and safety of your child, it will be shared with school staff as needed while your child is enrolled at Christ the King Catholic school, unless you request otherwise in writing.

Student Name: _____

Grade: _____ **Date of Birth:** _____ ☐ **Male** ☐ **Female**

Life Threatening Medical Conditions: WA State law requires a medication/treatment order from a Health Care Provider if your child's health condition will put your child in danger during the school day. Written orders must be received by the School Nurse with a care plan and medications **BEFORE YOUR CHILD CAN ATTEND SCHOOL.**

Does your child have a **LIFE THREATENING HEALTH CONDITION**? ☐ NO ☐ YES

If yes, please state condition:

☐ **NO** ☐ **YES**	Severe allergic reaction to bee sting? Please describe reaction: Anaphylactic: ☐ NO ☐ YES
☐**NO** ☐**YES**	Severe allergic reaction to **food or nuts**? Type: Anaphylactic: ☐NO ☐YES Please describe reaction:
☐ **NO** ☐ **YES**	Mild allergic reaction to **food, nuts or other**? Type: Please describe reaction:
☐ **NO** ☐ **YES**	Asthma? Will your child require asthma management during school hours? ☐ NO ☐YES
☐ **NO** ☐ **YES**	Diabetes? Type: Self-Manage: ☐NO ☐YES Pump: ☐NO ☐YES
☐ **NO** ☐ **YES**	Heart Condition? Diagnosis: Pacemaker: ♈ NO ♈ YES
☐ **NO** ☐ **YES**	Bleeding Disorder? Diagnosis:
☐ **NO** ☐ **YES**	Seizure/Neurological Disorder? Please describe:
☐ **NO** ☐ **YES**	GI/Feeding Condition? Please describe:
☐ **NO** ☐ **YES**	Bowel/Bladder Condition? Please describe:
☐ **NO** ☐ **YES**	Other health concerns?
☐ **NO** ☐ **YES**	Does your child have any other condition that would affect classroom performance or PE activities? Please describe:
☐ **NO** ☐ **YES**	Behavioral/Emotional Concerns:
☐ **NO** ☐ **YES**	Visual Impairment? ☐ Glasses ☐ Contacts Date of last eye exam:
☐ **NO** ☐ **YES**	Hearing Impairment? Hearing Aids ☐ NO ☐ YES Date of last hearing exam:

Health Insurance Company: _____

Primary Care Provider: _____ **Last exam:** _____

Dentist: _____ **Last dental exam:** _____

Daily Medications

*State law requires written authorization from a Health Care Provider and parent before **any** medication, prescription or over the counter, can be given at school. Please complete the medication administration form for any medications to be given at school.*

☐ NO ☐ YES. Medication needs at school: Please specify: (authorization needed) _____

☐ NO ☐ YES. Medication needed at home: Please specify: _____

Parent/Guardian Contact Phone Numbers: Please order from 1-3 which number to call first.

☐ **Cell:** _____ ☐ **Work:** _____ ☐ **Home:** _____

Parent or Legal Guardian (Printed Name): _____

Parent or Legal Guardian (Signature) _____ Date: _____

HEALTH POLICIES

Medical Emergencies

In the event my child has a medical emergency, Christ the King Montessori preschool will attempt to contact me, or the emergency contacts listed (if I cannot be reached). I authorize CKMP to call an ambulance to transport my child for medical treatment to the closest hospital or medical facility. Staff is trained in pediatric first aid and CPR. I authorize staff of Christ the King Montessori staff to administer first aid and/or CPR on my child. My child's health information may be viewed by staff, when necessary, as well as state licensors to ensure compliance.

Injuries

If a child is injured at school and needs further first aid or a visit to the doctor, parents/guardians will be called immediately. If we cannot reach you, we will contact the next person listed on your emergency form. It is extremely important that we have accurate information. PLEASE KEEP THIS INFORMATION UPDATED. Please notify us of any changes on your child's emergency form, especially changes in address, home, work or cell phone numbers, etc.

Illness

Children with any of the following symptoms are not permitted to remain in care. Parents/guardian or emergency contact will be notified to pick up the child. Child will be separated from the group and cared for by staff until pick up.

1. **Fever** of at least 100 º F as read underarm (axillary temp.): must be 24 hours fever free before returning to school.
2. **Vomiting:** one or more occasions within the past 24 hours.
3. **Diarrhea:** one or more watery stools within the past 24 hours or any bloody stool
4. **Rash:** especially with fever or itching
5. **Eye discharge or conjunctivitis (pinkeye):** until clear or until 24 hours of antibiotic treatment.
6. **Sick appearance, not feeling well, and/or not able to keep up with program activities**.
7. **Open or oozing sores**: unless properly covered **and** 24 hours has passed since starting antibiotic treatment if antibiotic treatment is necessary.
8. **Lice or scabies:** head lice: until no nits are present. Scabies: until after treatment has begun.

Following exclusion, children are readmitted to the program when they no longer have any of the above symptoms and/or Public Health exclusion guidelines for childcare are met.

We notify parents and guardians when their children may have been exposed to a communicable disease or condition (other than the common cold) and provide them with information about that disease or condition. We notify parents and guardians of possible exposure by email or paper flyer in parent mailbox to each family maintaining confidentiality.

In order to keep track of contagious illnesses (other than the common cold), an Illness Log is kept. Each entry includes the child's name, classroom, and type of illness. This is located in the first aid cabinet. We maintain confidentiality of this log by keeping it in a notebook in the cupboard.

No rectal or ear temperatures are taken. Digital thermometers are used. *(Oral temperatures may be taken for preschool through school age children if single use covers are used over the thermometer. Glass thermometers contain mercury, a toxic substance, and are therefore should not be used. Temperature strips should not be used because they are frequently inaccurate.)*

I have read and understand the Christ the King Montessori Preschool's Emergency Medical Care, Injury and Illness Policies. In signing below, I agree to abide by these policies.

Parent or Legal Guardian (Printed Name): _____

Parent or Legal Guardian Signature: _____ Date: _____

Pesticide Policy

Records of all pesticide applications to center facilities and landscapes, including a list of active ingredients and copies of Pre-Notification and Notification postings of applications are readily accessible to families and maintained on file at the center as required by state licensing requirements in Washington.

As required by law, the summary will include the product names of all pesticides, active ingredients, quantities of each pesticide, and amount of tank mix applied. Families and staff will be notified at least forty-eight (48) hours before a building/structural pesticide application. The pre-notification requirements do not apply if the indoor application is made when the center is not occupied by children or staff for at least two (2) consecutive days after the application (i.e. Friday evening).

The pre-notification requirements do not apply to any emergency application for control of pests that pose an immediate human health or safety threat, such as an application to control stinging insects. When an emergency application is made, families will be notified by the end of the center's business day.

Disaster Plan

In compliance with Washington State licensing, a copy of our disaster plan is available for parents of children enrolled in our program to read and review. Please contact the center director, Kelly Buchanan, with any questions.

I have received and reviewed Christ the King Montessori Preschool's pesticide policy and have had the opportunity to review the preschool disaster plan.

Parent or Legal Guardian Signature: _____ Date: _____

ALLERGY HEALTH CARE PLAN

Child's Name: _____ Today's Date: _____

☐ No Known Allergies

Foods that child must not consume	Reaction	Appropriate Food Substitutes

Any other special dietary requirements due to the health condition?

If you child has allergies, please have your child's physician complete the **Allergy and Anaphylaxis Emergency Plan.** The plan must be returned signed by both the physician and a parent.

Please update annually.

DEVELOPMENTAL HISTORY QUESTIONAIRE

Child's Name: _____

DEVELOPMENTAL AND SOCIAL

Language spoken at home _____

Any concerns about development? _____

Does your child have any difficulties with speech or communication? _____

Who resides in the house besides parents? _____

Does your child have more than one home? _____

Does your child have sibling who do not live in their primary residence? If yes, please list siblings name and where they live. _____

Siblings

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Has your child been in daycare or another preschool class? ☐Yes ☐No

Did that meet or exceed your expectations? Please explain. _____

What is your child's temperament like? Please describe. _____

What methods do you find most effective in dealing with misbehavior? _____

What methods do you find most effective in recognizing good behavior? _____

How does your child act when they are ill, hungry or tired? _____

How does your child react to new people or situations? _____

Does your child like to play in groups or alone? _____

Do you read to your child daily? ☐Yes ☐No If yes, how long? _____

How much time does your child spend watching TV each day? _____

How much time does you child spend playing computer or video games each day? _____

Is your child afraid of anything in particular? _____

What are your child's favorite activities and/or toys? _____

HEALTH

Does your child have any special needs or require any special services? _____

Have they had any serious illnesses or hospitalizations? _____

Do they have any disabilities, allergies *(Please be sure to compete Allergy Health Care Plan & Allergy Anaphylaxis Emergency Plan)* or any physical conditions or concerns? _____

Does your child take any medications regularly? Please list and fill our medication authorization form if they need to be given at school. _____

Does your child have a history of any injury to the teeth or gums? _____

Does your child complain about any gum or tooth pain? _____

NUTRITION

Does your child have any difficulty eating? ☐Yes ☐No If yes, please explain… _____

What does your child eat with? ☐Spoon ☐Fork ☐Fingers ☐Other _____

*Please fill out allergy information on the allergy health care plan and allergy anaphylaxis emergency plan. *

SLEEP

What time does your child go to bed at night? _____ Wake up in the morning? _____

Does your child take a nap? ☐ Yes ☐ No ☐ Occasionally How long? _____

At home, where does your child sleep? ☐ In their bed ☐ With parents ☐ Other _____

Any special concerns with sleeping? _____

TOILETING

Is your child toilet trained? ☐ Yes ☐ No

Does you child have accidents? ☐ Yes ☐ No How often? _____

What does your child use for toileting at home? ☐ Regular ☐ Potty chair ☐ Other _____

Does your child have any problems with diarrhea or constipation? Please explain… _____

_____

Hand Lotion Authorization Form

— as needed —

Child's Name:	Date of Birth & Age:

Name of Lotion (select option you would like to authorize):

☐ **Provider Supplied:** Aveeno Kids - face and body gel cream

☐ **Parent Supplied:**

Start Date:	Stop Date: (up to 12 months after 'Start Date')
08 / / 25	/ /

Special Instructions:

- Hand lotion should always be kept in an area inaccessible to children.
- Use of hand lotion must be supervised by an adult to prevent ingestion.
- Not for use related to medical issues such as eczema.

I authorize the use of the above hand lotion for my child.

_____ _____

Parent/Guardian Signature **Date**

Reason for item:	To moisturize hands
Route:	Topical
Amount to be given:	Refer to manufacturer's label
Times to be applied:	When hands are dry/cracked
Storage:	Room temperature

Sunscreen Authorization Form

(Program-Provided/Bulk Sunscreen)

Child's Name:	Date of Birth & Age: (Do not apply on infants 6 months & younger without written permission from health care provider)
Start Date: 8 / / 25	Stop Date: (up to 12 months after 'Start Date') / /
Special Instructions: (Include previous sunscreen reactions)	

I authorize the use of the following "program-provided" sunscreen on my child.

_____ _____

Parent/Guardian Signature **Date**

Program-Provided Sunscreen *(to be completed by child care provider)*

Name of Sunscreen & SPF: 50 Aveeno Kids, mineral Sunscreen Expiration Date: / /	Active Ingredients: Zinc Oxide please refer to www.Aveeno.com
Possible Side Effects: n/a	Other Label Information: hypo allergenic, tear free, free of parabens, phthalates and fragrance

Reason for medication: Protection from sun
Amount to be given: Cover exposed areas of skin
Route: Topical
Times to be applied: 30 minutes before exposure to the sun, and reapplied every two hours if remaining outdoors.
Storage: Room temperature

Washington State Department of Health

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	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	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)						
COVID-19						
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: 19_____
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 Pediarix 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).