

## **Pullman Parks and Recreation Preschool Forms**

**Please fill out and return to  
the office at the Pioneer  
Center or to your child's  
Preschool Teacher before  
attending class.**

**Thank You!**





**For Office Use:**

Classroom: \_\_\_\_\_ MWF or TuTh AM or PM

**Pullman Parks & Recreation Preschool  
Child Information Sheet 2016-2017**

**Please Print Clearly**

Today's Date \_\_\_\_\_

**Child's full name** \_\_\_\_\_ Birthday \_\_\_\_\_  
First Middle Last

Name(s) used by family or preferred for school \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

**Please give the e-mail address you would like the monthly Preschool Newsletter sent to:**

**Parent / Guardian Name:** \_\_\_\_\_ Age \_\_\_\_\_

1<sup>st</sup> Phone # \_\_\_\_\_ 2<sup>nd</sup> Phone # \_\_\_\_\_

Occupation \_\_\_\_\_

**Parent / Guardian Name:** \_\_\_\_\_ Age \_\_\_\_\_

1<sup>st</sup> Phone # \_\_\_\_\_ 2<sup>nd</sup> Phone # \_\_\_\_\_

Occupation \_\_\_\_\_

Family Hobbies/Interest \_\_\_\_\_

**List ANY allergies:** \_\_\_\_\_

**List name and amount of any regular medication (s):** \_\_\_\_\_

Has your child had any serious illness, operations, or accidents? Yes No please describe: \_\_\_\_\_

Are there any special considerations we should make for your child due to his/her general physical conditions? \_\_\_\_\_

Has either parent been divorced? Yes No Separated? Yes No previously married? Yes No  
Either parent deceased? Yes No Remarried? Yes No

**Specify custody arrangements:** \_\_\_\_\_



Other Adult Family members in the household:

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Children – please list all children in order of birth (including child enrolled in this program:

Name \_\_\_\_\_ Sex M F Birth date \_\_\_\_\_

What is the dominant language used in the home? \_\_\_\_\_

Other languages used in the home? \_\_\_\_\_

Which hand does your child prefer? Right Left Neither Both

What words does child use for urine? \_\_\_\_\_ Bowel movement? \_\_\_\_\_

What responsibility does your child assume towards toileting? \_\_\_\_\_

\_\_\_\_\_

Who does your child prefer to play with? Alone Other children Adults

What types of activities does your child enjoy sharing with family members? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List favorite toys and activities:

Indoor

Outdoor

<u>Indoor</u>	<u>Outdoor</u>
_____	_____
_____	_____
_____	_____

Your child's favorite companions (please specify if they are real or imaginary): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe your child's interest in literacy activities (reading, writing, drawing): \_\_\_\_\_

\_\_\_\_\_

Are there any other of your child's interests, concerns, or fears should we be aware of? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**For Office Use:**

Classroom: \_\_\_\_\_

MWF or TuTh

AM or PM

**Pullman Parks & Recreation Preschool**

# Emergency Information Form 2016-2017

**Please Print Clearly**

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

Child's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

1<sup>st</sup> Phone # \_\_\_\_\_ 2<sup>nd</sup> Phone # \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

1<sup>st</sup> Phone # \_\_\_\_\_ 2<sup>nd</sup> Phone # \_\_\_\_\_

Home Address \_\_\_\_\_

**In case of emergency when parents/guardian can't be reached, please notify:**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Child's doctor \_\_\_\_\_ Phone \_\_\_\_\_

List all allergies \_\_\_\_\_

### **Emergency Medical Treatment Procedure**

In the event of an emergency, whenever possible, parents or persons listed above will be notified and asked to take their child to their family physician for medical treatment. If no parent or guardian can be reached, we will call 911 to have the child transported by ambulance to the local hospital.

I, the undersigned, in consideration of your accepting \_\_\_\_\_ (child's name), hereby assume all risk and hazards of the conduct of this preschool program and release all claims and rights for damages my child may have against the City of Pullman, its employees, or agencies co-sponsoring this program. I also acknowledge for my child that the City of Pullman provides no medical coverage of any kind for any accident or injuries that might result in participation in city sponsored programs.

In the event that my child is injured or should require medical attention, I hereby authorize Pullman Parks and Recreation to secure necessary medical treatment. Confirmation of this authorization should be made with me prior to treatment by calling me at the above listed phone number. In case I cannot be reached for an emergency, medical treatment as described above may proceed without further authorization.

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



**For Office Use:**

Classroom: \_\_\_\_\_ MWF or TuTh AM or PM

**Pullman Parks & Recreation Preschool  
Release Form 2016-2017**

**This list should include all parent/guardians, grandparents, and friends that you authorize to pick up your child from Pullman Parks & Recreation Preschool. Your child will not be released to someone not listed below. You may update this list anytime during the school year.**

**Please Print Clearly**

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

**The following people are authorized to pick up** \_\_\_\_\_  
(Child's name)

 \_\_\_\_\_ Mother Father Guardian \_\_\_\_\_  
Name: Parent/Guardian Phone

\_\_\_\_\_ Mother Father Guardian \_\_\_\_\_  
Name: Parent/Guardian Phone

 \_\_\_\_\_ Friend Relative Other/Sitter \_\_\_\_\_  
Name: Phone

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

**If you cannot be reached at home or work, please provide a schedule detailing where you will normally be during your child's preschool schedule.**

\_\_\_\_\_ Phone \_\_\_\_\_  
Location

\_\_\_\_\_ Phone \_\_\_\_\_  
Location



**For Office Use:**

Classroom: \_\_\_\_\_

MWF or TuTh

AM or PM

**Pullman Parks & Recreation Preschool**  
**Parental Permission for**  
**Preschool Field Trips 2016-2017**

The undersigned, hereby give my child \_\_\_\_\_  
permission to participate in Pullman Parks & Recreation Preschool field trip  
taken during the 2016-2017 preschool year. (Including but not limited to: walks  
and or bus rides to the city parks, Neill Public Library, Police Station, Fire  
Station, and local businesses). I will not hold the City of Pullman or any of  
those participating and/or supervising in the activity, responsible for any injury  
incurring during or en-route to the activity.



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

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone



**For Office Use:**

Classroom: \_\_\_\_\_ MWF or TuTh      AM or PM

**Pullman Parks & Recreation**

## **Preschool Payment Policy 2016-2017**

- **Current students must register by the 15<sup>th</sup> of each month to guarantee their spot in the next month's preschool. *New students may register for the next month's preschool on the 16<sup>th</sup> of each month.***
- Children must be picked up promptly at the end of class. A \$10.00 late fee will be charged for each ten minutes your child remains at the preschool.
- Children who have a fever or are feeling ill should not attend preschool as we have others to consider. Children will be sent home if they become ill or have a fever.
- Children will only be released to parents/legal guardians or persons designated on the release form. If you want someone to pick up your child and they are not on the release form please provide them with a signed permission slip from you.

I have read and fully understand the Pullman Parks and Recreation Preschool Policies.



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

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





## Washington State Immunization Forms

All students are required by the State of Washington to provide up-to-date immunization records for any child in childcare or preschool. You will find the forms attached here in the Preschool Parent Manual.

1. Please fill out the following forms.
  - a. Fill out the form provided or if your doctor has the ability to print a copy of the record in the state required format, this is acceptable.
  - b. You may opt to sign the Certificate of Exception for all or part of the immunization requirements.
  - c. Copies of immunization records are not acceptable.
  - d. You will find attached a copy of the state requirements for attendance in child care/preschool.
2. Please sign the form before returning to Parks & Recreation.





# Certificate of Immunization Status (CIS)

DOH 348-013 January 2015

Office Use Only:

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Signed Cert. of Exemption on file?  Yes  No

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

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

Symbols below:  
 Required for School and Child Care/Preschool  
 Required for Child Care/Preschool Only  
 Recommended, but not required

I certify that the information provided on this form is correct and verifiable.

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Vaccine		Dose		Date			Parent/Guardian Signature Required		Date
<b>◆ Hepatitis B (Hep B)</b>									
	1								
	2								
	3								
<b>or Hep B - 2 dose alternate schedule for teens</b>									
	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)</b>									
	1								
<b>■ Tetanus, Diphtheria (Td)</b>									
	1								
	2								
<b>● Haemophilus influenzae type b (Hib)</b>									
	1								
	2								
	3								
	4								
<b>■ Influenza (flu, most recent)</b>									
<b>◆ Pneumococcal (PCV, PPSV)</b>									
	1								
	2								
	3								
	4								
	5								
<b>◆ Polio (IPV, OPV)</b>									
	1								
	2								
	3								
	4								
<b>◆ Measles, Mumps, Rubella (MMR)</b>									
	1								
	2								
	3								
	4								
<b>◆ Varicella (chickenpox)</b>									
	1								
	2								
<b>■ Hepatitis A (Hep A)</b>									
	1								
	2								
<b>■ Human Papillomavirus (HPV) – does not print from the IIS; write dates in by hand</b>									
	1								
	2								
	3								
<b>■ Meningococcal (MCV, MPSV)</b>									
	1								
	2								

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified.

**Mark option 1, 2, OR 3 below (see # 5 on back)**

- 1)  Chickenpox disease verified by printout from the Immunization Information System (IIS) Must be marked by printout (not by hand) to be valid.
- 2)  Chickenpox disease verified by healthcare provider (HCP) If you choose this box, mark 2A OR 2B below.  
 2A)  Signed note from HCP attached OR  
 2B)  HCP sign here and print name below:

Licensed healthcare provider signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)

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

- 3)  Chickenpox disease verified by school staff from the Immunization Information System

**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 healthcare provider signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)

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



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

**#1 To print with information filled in:** First, ask if your healthcare provider's office puts vaccination history into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS**, and return it to school or child care. If your provider's office does not use the IIS, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

**EXAMPLE**

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

**#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 ▶

**#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 had chickenpox (varicella) disease and not the vaccine, **use only one** of these three options to record this on the CIS:

- 1)  If your child's CIS is printed directly from the IIS (by your healthcare provider or school), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the IIS printout (not by hand).
- 2)  If your healthcare provider can verify that your child had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your provider, or 2B if your provider signs and dates in the space provided. Be sure your provider's full name is also printed.
- 3)  If school staff access the IIS and see verification that your child had chickenpox, they will mark box 3.

**#6** Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your healthcare provider fill in this box. Ask your provider 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**, and return to the school or child care.

Vaccine Trade Names in alphabetical order				(For updated lists, visit <a href="https://fortress.wa.gov/doh/cpir/iweb/homepage/complete-list-of-vaccine-names.pdf">https://fortress.wa.gov/doh/cpir/iweb/homepage/complete-list-of-vaccine-names.pdf</a> )			
Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Ipol	IPV	PedvaxHIB	Hib	Twinnx (Twinnx)	Hep A + Hep B
Adacel	DTaP	Infanrix	DTaP	Pentacel (Pntcl)	DTaP + Hib + IPV	Vaqta	Hep A
Adjuv	Flu	Kinrix (Kinrx)	DTaP + IPV	Pneumovax	PPSV or PPV23	Varivax	Varicella
Boostrix	Flu	Menactra	MCV or MCV4	Prevnar	PCV or PCV7 or PCV13		
Cervarix	HPV2	MenHibrix (M/hibrix)	Meningococcal C/Y-HIB-PRP	ProQuad (PrQd)	MMR + Varicella		
Daptacel	DTaP	Menomune	MPSV or MPSV4	Recombivax HB	Hep B		
Eugenix-B	Hep B	Menveo	Meningococcal	Rotanix	Rotavirus (RV1)		
Fluarix	Flu	Pediarix (Pdrx)	DTaP + Hep B + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order				(For updated lists, visit <a href="https://fortress.wa.gov/doh/cpir/iweb/homepage/complete-list-of-vaccine-names.pdf">https://fortress.wa.gov/doh/cpir/iweb/homepage/complete-list-of-vaccine-names.pdf</a> )			
Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus, acellular Pertussis	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 (ITV 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

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 January 2015



# 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

Disease	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 valid 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."

**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 or 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."

If you have a disability and need this form in a different format please call 1-800-525-0127 (TDD/TTY Call 711)



**VACCINES REQUIRED FOR CHILD CARE/PRESCHOOL ATTENDANCE**  
July 1, 2015 – June 30, 2016

	Hepatitis B	DTaP (Diphtheria, Tetanus, Pertussis)	Hib ( <i>Haemophilus influenzae</i> type B)	Polio	PCV (Pneumococcal Conjugate)	MMR (Measles, Mumps, Rubella)	Varicella (Chickenpox)
<b>By 3 Months</b> (on or before last day of mo 2)	<b>2 doses</b> May get Dose 1 at birth and Dose 2 as early as 1 month of age	<b>1 dose</b>	<b>1 dose</b>	<b>1 dose</b>	<b>1 dose</b>	<b>Not given before 12 months of age</b>	<b>Not given before 12 months of age</b>
<b>By 5 Months</b> (on or before last day of mo 4)	<b>2 doses</b>	<b>2 doses</b>	<b>2 doses</b>	<b>2 doses</b> May get Dose 2 as early as 4 months of age	<b>2 doses</b>		
<b>By 7 Months</b> (on or before last day of mo 6)	<b>2 doses</b>	<b>3 doses</b> May get Dose 3 as early as 6 months of age	<b>3 doses</b>	<b>2 doses</b>	<b>3 doses</b>		
<b>By 16 Months</b> (on or before last day of mo 15)	<b>2 doses</b>	<b>3 doses</b>	<b>4 doses</b>	<b>2 doses</b>	<b>4 doses*</b>	<b>1 dose</b> May get Dose 1 as early as 12 months of age	<b>1 dose</b> May get Dose 1 as early as 12 months of age <b>OR</b> <b>Healthcare provider verifies disease</b>
<b>By 19 Months</b> (on or before last day of mo 18)	<b>3 doses</b>	<b>4 doses</b> May get Dose 4 as early as 12 months as long as 6 months separate Dose 3 and Dose 4	<b>4 doses</b>	<b>3 doses</b>	<b>4 doses*</b>	<b>1 dose</b>	<b>1 dose</b> <b>OR</b> <b>Healthcare provider verifies disease</b>
<b>By 7 Years</b> (on or before last day of year 6) <b>or by Kindergarten Entry</b>	<b>3 doses</b>	<b>5 doses</b>	<b>Not given after 5 years of age unless child has medical condition</b>	<b>4 doses</b>	<b>Not given after 5 years of age unless child has medical condition</b>	<b>2 doses</b>	<b>2 doses</b> <b>OR</b> <b>Healthcare provider verifies disease</b>

\*Some children may get 5 total doses. A single supplemental dose of PCV13 is recommended, but not required, for all children aged 14–59 months who got 4 doses of PCV7.

- School-aged children (K-12) in before and after-school programs must meet the immunization requirements for their grade in school.
- Find information on other vaccines recommended, but not required, for child care/preschool attendance: [www.immunize.org/cdc/schedules/](http://www.immunize.org/cdc/schedules/)
- Review the Individual Vaccine Requirements Summary for more detailed information: [www.doh.wa.gov/immunization/schoolandchildcare/VaccineRequirements.aspx](http://www.doh.wa.gov/immunization/schoolandchildcare/VaccineRequirements.aspx)





## Minimum Age & Interval for Valid Vaccine Doses

Vaccine	Dose #	Minimum Age	Minimum Interval Between Doses	Notes
Hepatitis B (HepB)	Dose 1	Birth	4 weeks between Dose 1 & 2	<ul style="list-style-type: none"> <li>The final dose in the series should be given at least 24 weeks of age.</li> </ul>
	Dose 2	4 weeks	8 weeks between Dose 2 & 3	
	Dose 3	24 weeks	16 weeks between Dose 1 & 3	
	Dose 1	6 weeks	4 weeks between Dose 1 & 2	
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
Diphtheria, Tetanus, and Pertussis (DTaP/DT)	Dose 3	14 weeks	6 months between Dose 3 & 4	<ul style="list-style-type: none"> <li>Typical vaccine schedule: 2, 4, 6, and 15-18 months of age.</li> <li>Recommended: 6 months between Dose 3 and Dose 4, but at least 4 months minimum interval acceptable.</li> </ul>
	Dose 4	12 months	6 months between Dose 4 & 5	
	Dose 5	4 years	--	
	Dose 1	6 weeks	4 weeks between Dose 1 & 2	
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
Haemophilus influenzae type B (Hib)	Dose 3	14 weeks	8 weeks between Dose 3 & 4	<ul style="list-style-type: none"> <li>If all 3 doses of PedvaxHIB given, only need 3 doses total.</li> <li>Only one dose required if the dose given on or after 15 months of age. Review the Individual Vaccine Requirements Summary for minimum doses required: <a href="http://www.doh.wa.gov/immunization/schoolandchildcare/VaccineRequirements.aspx">www.doh.wa.gov/immunization/schoolandchildcare/VaccineRequirements.aspx</a></li> </ul>
	Dose 4	12 months	--	
	Dose 1	6 weeks	4 weeks between Dose 1 & 2	
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	8 weeks between Dose 3 & 4	
Pneumococcal Conjugate (PCV7 or PCV13)	Dose 4	12 months	--	<ul style="list-style-type: none"> <li>A single supplemental dose of PCV13 recommended for all children 14-59 months of age who got 4 doses of PCV7.</li> <li>Only one dose required if the dose given on or after 24 months of age. Review the Individual Vaccine Requirements Summary for minimum doses required: <a href="http://www.doh.wa.gov/immunization/schoolandchildcare/VaccineRequirements.aspx">www.doh.wa.gov/immunization/schoolandchildcare/VaccineRequirements.aspx</a></li> </ul>
	Dose 1	6 weeks	4 weeks between Dose 1 & 2	
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	8 weeks between Dose 3 & 4	
	Dose 4	12 months	--	
Polio (IPV or OPV)	Dose 1	6 weeks	4 weeks between Dose 1 & 2	<ul style="list-style-type: none"> <li>Three doses acceptable if child got Dose 3 on or after the 4<sup>th</sup> birthday.</li> </ul>
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	6 months between Dose 3 & 4	
	Dose 4	4 years	--	
	Dose 1	12 months	4 weeks between Dose 1 & 2	
Measles, Mumps, and Rubella (MMR or MMRV)	Dose 1	12 months	4 weeks between Dose 1 & 2	<ul style="list-style-type: none"> <li>MMRV (MMR + varicella) may be used in place of separate MMR and varicella vaccines.</li> <li>Must get the same day as VAR <u>OR</u> at least 28 days apart.</li> <li>4-day grace <u>DOES</u> apply between doses of the same live vaccine such as MMR/MMR or MMRV/MMRV. The 4 day grace period <u>DOES NOT</u> apply between Dose 1 and Dose 2 of different live vaccines, such as between MMR and Varicella or between MMR and live flu vaccine.</li> </ul>
	Dose 2	13 months	--	
Varicella (chickenpox) (VAR)	Dose 1	12 months	3 months between Dose 1 & 2 (12 months through 12 years) 4 weeks between Dose 1 & 2 (13 years and older)	<ul style="list-style-type: none"> <li>Recommended: 3 months between varicella doses, but at least 28 days minimum interval acceptable. Minimum age of 13 months acceptable.</li> <li>Must get the same day as MMR <u>OR</u> at least 28 days apart.</li> <li>4-day grace <u>DOES</u> apply between doses of the same live vaccine; <u>DOES NOT</u> apply between doses of different live vaccines.</li> </ul>
	Dose 2	15 months	--	

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