

Household Child Vaccine Exemption

Section 1. Parent or Guardian Instructions

In order for this form to be valid, please:

- Fill in your child's information in Boxes 1 – 3.
- Read the Parent / Guardian Declaration.
- Provide your initials where indicated.
- Print your name, sign, and date in Boxes 4 – 5.
- **Have a provider complete Section 2 below of this form.**

1. CHILD'S LAST NAME

2. CHILD'S FIRST NAME / MIDDLE INITIAL

3. BIRTHDATE (MM/DD/YYYY)

I am the parent or legal guardian of the above named child. One or more required vaccines would be contrary to the health of the above named child¹.

Parent / Guardian Declaration

I understand that:

INITIAL

- _____ I will contact my licensor if anyone in my home contracts a serious infection or a communicable disease that is a threat to children in my care. At that time a "No Referral" will be put on my home until the contagion passes. If I am contacted for a placement, I will decline until the contagion has passed.
- _____ Exempting my child from any or 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.
- _____ The information provided on this form is complete and correct.

4. PRINT PARENT / GUARDIAN'S NAME

5. PARENT / GUARDIAN'S SIGNATURE

DATE

Section 2. Licensed Health Care Provider Instructions

In order for this form to be valid, please:

- Mark which disease(s) require a medical exemption, and write a **T** for Temporary or **P** for Permanent.
- Discuss the benefits and risks of immunizations with the parent or guardian.
- Read the Provider Declaration.
- Print your name, credentials, sign, and date in Boxes 6 – 7.
- A provider may grant an exemption only if there is a valid medical contraindication to a vaccine.

If caring for foster children under 2 years of age or for medically fragile children:

- Exemption for the **Pertussis Vaccine** must only be granted if the vaccine would be contrary to the child's health.
- Exemption for the **Influenza Vaccine** must only be granted if the vaccine would cause severe medical consequences.

DISEASE	MEDICAL (T / P)*	EXPIRATION DATE IF TEMPORARY
Diphtheria		
Hepatitis B		
Hib		
Measles		
Mumps		
Pertussis		
Pneumococcal		
Polio		
Rubella		
Tetanus		
Varicella		
Influenza		
All		

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.

6. PRINT PROVIDER'S NAME

7. PROVIDER'S SIGNATURE

DATE

¹ 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 by a licensed healthcare provider.