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| http://intranet.dcyf.wa.gov:8090/drupal-8.4.0/sites/default/files/graphics/DCYF-Logo-BW.jpg | | LICENSING DIVISION (LD)  **Vaccine Exemption** | | | | | | |
| **Name of Foster Home Licensee** | | | | | | | | |
| **Applicant or Household Member (including children) Information** | | | | | | | | |
| LAST NAME | FIRST NAME / MIDDLE INITIAL | | | | | BIRTHDATE (MM/DD/YYYY) | | |
| **Licensed Health Care Provider Instructions** | | | | | | | | |
| The individual listed above is required to have the vaccination(s) listed below.  Per WAC 110-148-1320(6)(c), we may grant a medical exception to this requirement if the immunization is contrary to the individual’s health as documented by a licensed health care provider. | | | | | | | | |
| If caring for under age 2, and/or for medically fragile children, all household members must have the following immunizations:   1. Whooping cough (Pertussis) 2. Influenza (this is required annually, once per school year) | | | | | All children (under age 18) in the household must have the following immunizations, per the [WA OSPI schedule](https://www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization#reqs):  (<https://www.doh.wa.gov/CommunityandEnvironment/Schools/Immunization>)   1. Chickenpox (Varicella); 2. Diphtheria; 3. German measles (Rubella); 4. Haemophilus influenzae type B disease; 5. Hepatitis B; 6. Measles (Rubeola); 7. Mumps; 8. Pneumococcal disease; 9. Polio (Poliomyelitis); 10. Tetanus; and 11. Whooping cough (Pertussis) | | | |
| As a licensed health care provider, if you believe one of more of these immunizations is contrary to the health of the individual listed above, please complete the fields below. You must complete one line per immunization. | | | | | | | | |
| IMMUNIZATION | | | | REASON | | | TEMPORARY OR PERMANENT? | IF TEMPORARY: EXPIRATION DATE |
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| **Provider Declaration** | | | | | | | | |
| I declare that:   * I am a qualified MD, ND, DO, ARNP, or PA licensed under Title 18 RCW. * I have discussed the benefits and risks of immunizations with the applicant/household member (or their parent/legal guardian, if a minor). * The individual above also does not qualify for an alternate immunization (e.g. RIV3). * I have received the individual’s medical history and attest that the information provided on this form is complete and correct. | | | | | | | | |
| PRINT PROVIDER’S NAME | | | PROVIDER’S SIGNATURE DATE | | | | | |
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