

Vaccine Consent Form

YOU MUST COMPLETE BOTH SIDES OF THIS FORM

Name of School Student Attends:				Student's Grade	
Last Name (Please Print)	First Name	MI	Date of Birth	Male	Female
Street Address (include Apt # if applicable)			City	State	Zip
Parent/Guardian – Please PRINT Name		Daytime Phone Number		Cell Phone Number	
Insurance:					
Blue Cross Blue Shield# _____					
UnitedHealthcare# _____ Group #: _____					
Tufts# _____					
Neighborhood Health Plan# _____					
Cigna# _____					
Other _____					
No Insurance _____					
Race: (Check one or more) White Asian Black or African American American Indian or Alaska Native					
Native Hawaiian or Other Pacific Islander Unknown or Other Race					
Ethnicity: Not Hispanic or Latino Hispanic or Latino Unknown					

IMMUNIZATION SCREENING QUESTIONNAIRE

Parent/Guardian: Please ej gemthe answers to the questions below to help us determine which vaccines may be given.

1. Does your child have allergies to medications, food, or any vaccine? Yes No
If yes, please explain: _____
2. Has your child ever had a serious reaction to a vaccine in the past? Yes No
If yes, to what vaccine and when? _____
3. Has your child ever had a seizure or brain problem? Yes No
If yes, please indicate current status: _____
4. Does your child have leukemia, AIDS, or any other immune system condition? Yes No
5. Does your child take cortisone, prednisone, other steroids or anti-cancer drugs, or has he/she had x-ray treatment in the past three months? Yes No
6. Has your child received a blood transfusion, blood products, or been given a medicine called immune (gamma) globulin in the past year? Yes No
7. Has your child received any vaccinations in the past 4 weeks? Yes No
If yes, which vaccine(s) _____

STUDENT NAME _____

STUDENT DATE OF BIRTH _____

VACCINATION HISTORY OBTAIN INFORMATION FROM PHYSICIAN	PLEASE SIGN IF VACCINE IS NEEDED
HEPATITIS B (3 shots) _____ Date Vac #1 Date Vac #2 Date Vac #3	HEPATITIS B: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I understand that 3 shots are necessary for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE HEPATITIS B VACCINE(S) Signature: _____ Date: _____
MMR (2 shots) _____ Date Vac #1 Date Vac #2	MMR: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I understand that 2 shots are necessary for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE MMR VACCINE(S) Signature: _____ Date: _____
TDAP Td _____ Date Vaccine Date Vac #2	TDAP: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE TDAP VACCINE Signature: _____ Date: _____
MENINGITIS _____ Date Vac #1 Date Vac #2 Date Vac #3	MENINGITIS: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE MENINGITIS VACCINE Signature: _____ Date: _____
CHICKENPOX _____ Date Vac #1 Date Vac #2 _____ Date Had Chickenpox	CHICKENPOX: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I understand that 2 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE CHICKENPOX VACCINE(S) Signature: _____ Date: _____
POLIO (3-4 shots) _____ Date Vac #1 Date Vac #2 Date Vac #3 _____ Date Vac #4	POLIO: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I understand that 4 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE POLIO VACCINE(S) Signature: _____ Date: _____
HPV (3 shots) _____ Date Vac #1 Date Vac #2 Date Vac #3	HUMAN PAPILLOMAVIRUS VACCINE: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I understand that 3 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. Signature: _____ Date: _____
HEPATITIS A (2 shots) _____ Date Vac #1 Date Vac #2	HEPATITIS A: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I understand that 2 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE HEPATITIS A VACCINE(S) Signature: _____ Date: _____

Rev: 4/11/13

PLEASE PRINT AND RETURN TO SCHOOL NURSE