

VACCINE CONSENT FORM



PERSONAL INFORMATION			Year of Graduation: _____		
School Student Attends: _____					
Print Student Name Last: _____		First: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: ____/____/____	
Street Address: _____		City: _____	St: _____	Zip: _____	
Print Parent/Guardian Name: _____			Daytime Phone #: _____		

HEALTH INSURANCE INFORMATION

Name of Insurance Company: _____

Member Id: _____ Group # (if applicable): _____

No Insurance

MEDICAL SCREENING FOR VACCINE ELIGIBILITY

- Does your child have allergies to medications, food, or any vaccine? Y / N If yes, list: _____
- Has your child ever had a serious reaction to a vaccine in the past? Y / N If yes, explain: _____
- Has your child ever had a seizure or brain problem? Y / N
- Does your child have leukemia, AIDS, or any other immune system condition? Y / N
- Does your child take cortisone, prednisone, steroids or anti-cancer drugs? Y / N
- Received a blood transfusion, blood products, or been given immune (gamma) globulin in the past year? Y / N
- Has your child received any vaccinations in the past 4 weeks? Y / N If yes, which vaccine(s): _____

CONSENT FOR VACCINATION IN SCHOOL SETTING

I have viewed the Vaccine Information Statement(s) for the vaccine(s) requested at <http://www.immunize.org> or obtained a hard copy by calling the Rhode Island Department of Health at 401-222-5960. I understand the benefits and risks of the vaccine(s) requested.

I understand that a record of vaccinations administered in this program will be submitted to the statewide database, KIDSNET within 48 hrs of vaccination. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine.

PARENT SIGNATURE REQUIRED NEXT TO EACH VACCINE REQUESTED:

HEP A X _____	DATE: _____	Vaccination History <i>List Dates If Available</i>
HEP B X _____	DATE: _____	DOSE #1 _____ #2 _____
HPV X _____	DATE: _____	DOSE #1 _____ #2 _____ #3 _____
MMR X _____	DATE: _____	DOSE #1 _____ #2 _____
MENINGITIS X _____	DATE: _____	DOSE #1 _____ #2 _____ #3 _____
POLIO X _____	DATE: _____	DOSE #1 _____ #2 _____ #3 _____
TDAP / TD X _____	DATE: _____	TDAP: _____ TD: _____ TD: _____
CHICKEN POX X _____	DATE: _____	DOSE #1 _____ #2 _____ DATE DX: _____

The vaccine(s) checked should be given to the student named for whom I am authorized to make this request. I understand that all doses indicated for each vaccine are needed to receive full protection.

Return This Form To Your School Nurse