Vaccinate *before you* Graduate

VACCINE CONSENT FORM

PERSONAL INFORMATION

School Student Attends:			Year of Graduation:	
Print Student Name Last:	First:	☐ Male ☐ 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

1. Does your child have allergies to medications, food, or any vaccine? Y / N If yes, list: ______________
2. Has your child ever had a serious reaction to a vaccine in the past? Y / N If yes, explain:
   ____
3. Has your child ever had a seizure or brain problem? Y / N
4. Does your child have leukemia, AIDS, or any other immune system condition? Y / N
5. Does your child take cortisone, prednisone, steroids or anti-cancer drugs? Y / N
6. Received a blood transfusion, blood products, or been given immune (gamma) globulin in the past year? Y / N
7. 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:		*Vaccination History* *List Dates If Available*
HEP A X________________	DATE:________	DOSE #1________ #2________
HEP B X________________	DATE:________	DOSE #1________ #2________ #3________
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