Adolescent School Immunization Clinic Parental Consent Form

School Name _____ Clinic Date _____

In order for your child to obtain the adolescent vaccinations during this school based clinic, you must
1. **Complete** both sides of this form, 2. **Provide** previous vaccination records, and 3. **Sign & Date** this form.

A. INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT)

Student's Name Last _____ First _____ Middle _____

Student's Birth Date _____ Age _____ Gender *Male* *Female*

Parent/Guardian Name Last _____ First _____ Relationship _____

Student's Address _____ City _____ Zip Code _____

B. VACCINE ELIGIBILITY SCREENING (PLEASE CHECK APPROPRIATE BOX)

- ☐ **Medicaid** A child, 0 through 18 years of age, who has Medicaid as primary insurance.
- ☐ **American Indian/Alaskan Native** A child, 0 through 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance.
- ☐ **No Health Insurance** A child, 0 through 18 years of age, who does not have health insurance.
- ☐ **Insurance Does Not Cover Vaccines (Underinsured)** A child, 0 through 18 years of age, who has commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (these children are categorized as underinsured for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured).
- ☐ **Fully Insured** A child, 0 through 18 years of age, who has health insurance which provides coverage for vaccines. If primary insurance denies the claim and Medicaid is a secondary insurance, the healthcare provider will make the adjustment and bill Medicaid.

C. VACCINE HEALTH SCREENING (CIRCLE YES OR NO)

Please answer all questions about the student who will be receiving the vaccine(s). Answers will determine whether the student can be vaccinated at this time.

Yes No 1. Does the student have any allergies to medication, foods, or any vaccines?
If yes, please explain _____

Yes No 2. Has the student had a serious reaction to a vaccine in the past?

Yes No 3. Has the student had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?

Yes No 4. Has the student had a seizure, brain or other nervous system problem, including Guillain-Barré Syndrome?

Yes No 5. Does the student have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?

Yes No 6. Has the student taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?

Yes No 7. Has the student received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?

Yes No 8. Is the student pregnant or is there a chance she could become pregnant during the next month?

Yes No 9. Has the student received vaccinations in the past four (4) weeks?
If yes, please list vaccines _____

D. CONSENT TO VACCINATE

I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for the Meningococcal, Tetanus, Diphtheria, acellular Pertussis, and/or HPV vaccines. I have had a chance to ask questions and fully understand the benefits and risks of each of the indicated vaccines and ask the following vaccines be given to my child on the scheduled school clinic date (*check all that apply*):

- ☐ Meningococcal (MCV4)
- ☐ Tetanus, diphtheria, acellular pertussis (Tdap)
- ☐ HPV
- ☐ Meningococcal B (MenB)

I give permission to the _____ County Health Department, the Indiana State Department of Health, and/or their designees to vaccinate the student named on this form.

Signature of Parent/Guardian _____ Date _____

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E. TO BE COMPLETED BY PERSON ADMINISTERING VACCINE

Vaccine	Manufacturer/Lot Number/Expiration Date	Signature of vaccinator	Site (circle side)	Route	Date of VIS
MCV4			Left or Right Deltoid	IM	
MenB			Left or Right Deltoid	IM	
Tdap			Left or Right Deltoid	IM	
HPV9			Left or Right Deltoid	IM	

The HPV and MenB vaccines are not school requirements. However, it is a requirement of school-based clinics enrolled in the VFC program to offer the HPV and MenB vaccines to both boys and girls.

Entered into CHIRP By _____ Date _____