SCHOOL IMMUNIZATION CONSENT FORM

Please fill in form completely – required fields are marked with an asterisk (*)

***Student's Legal Last Name**:	***First Name:**	**MI:**
***Date of Birth**:_____ Month/Day/Year	***Parent/Guardian Last Name:**	***Parent/Guardian First Name:**
***Mailing Address**:	***City:**	***State**: Florida ***Zip:**
***Daytime Phone**:	***Student ID#:** _____ ***Grade:** _____	***School:**
Medical Insurance: _____	**Medical Insurance ID#** _____	**Medical Group#** _____
***Sex:** ☐ Male ☐ Female ☐Other	**Race:** ☐African American ☐Asian ☐White ☐American Indian/Alaskan Native ☐Other	**Ethnicity**: ☐ Hispanic ☐ Non-Hispanic

SELECT AND INITIAL THE VACCINE(S) YOU WOULD LIKE YOUR CHILD TO RECEIVE AT SCHOOL			
☐ TDAP (requirement)	_____(Initial)	☐ HPV (1st Dose)	_____(Initial)
☐ MEN ACWY	_____(Initial)	☐ HEPATITIS A	_____(Initial)

MEDICAL SCREENING QUESTIONS FOR CHILDREN AND TEENS – REQUIRED			
For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "**yes**" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.	**Yes**	**No**	**I don't know**
1. Does the child have allergies to medications, food, a vaccine component, or latex?			
YES:			
2. Has the child has a serious reaction to a vaccine in the past?			
YES:			

CONSENT FOR VACCINATION*

I have read or have had explained to me the information in the Vaccine Information Statement (VIS) for the disease(s) and vaccine that I have selected for my child above. I have checked and placed my initials next to the vaccine(s) that I wish for my child to receive during the vaccine clinic. I understand the benefits and risks of each vaccine. I understand that some vaccines are given in a series over a period of time and that I will need to follow up at my local Health Department or health care provider to complete. **I will contact the school nurse to withdraw this consent if my child is immunized before the date of the school clinic or for any reason.** Unless I sign a statement signifying otherwise, I allow immunization information to be entered into the Florida Shots and be releases to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status.

***Signature (Parent/Guardian):** _____ ***Date:** _____

***Print Name (Parent/Guardian):** _____

Clinical Use Only

Vaccine	Lot #	Site/Route	Vaccinator
TDAP		IM – LD/RD	
MEN ACWY		IM – LD/RD	
HPV		IM – LD/RD	
HEP A		IM – LD/RD	