

Vaccine Consent

Please complete and return to your school no later than **January 13, 2012**

PRINT the name of Student to receive vaccine (confirm the above name and birthdate)																
Last	First	Middle														
Address	Apt.	City	State	Zip Code												
Birth date	Age	Emergency Phone #														
<p>I would like my student to receive the following vaccinations:</p> <p><input type="checkbox"/> Tdap (See attached vaccine information statement)</p> <p><input type="checkbox"/> MCV4 (See attached vaccine information statement)</p> <p>Does your child have any allergies or any medical concerns? Please list: _____</p> <p>Please answer the following questions by circling the appropriate responses:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;">1. Has your student ever had a serious reaction after receiving a vaccination?</td> <td style="width: 5%;">Yes</td> <td style="width: 15%;">No</td> </tr> <tr> <td>2. Does your student have a chronic health condition that affects vaccination status?</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>3. Does your student take cortisone, prednisone, other steroids, or anti-cancer drugs?</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>4. During the past year, has your student received a blood transfusion or blood products?</td> <td>Yes</td> <td>No</td> </tr> </table> <hr/> <p>Mark one of the following that best describes your child's insurance status:</p> <p>_____ My student is either covered by Medicaid, has no health insurance, or has health insurance that does not cover the cost of vaccinations. A \$15 donation is suggested for each vaccine or a \$30 donation for both vaccines. Please make checks payable to Community Health Partners.</p> <p>_____ My student has insurance that covers Tdap and MCV4 or is/will turn 19 years old during spring 2012. I will contact my health care provider to receive these vaccinations through my medical clinic.</p> <p style="font-size: small;">I have reviewed and understand the Tdap and MCV4 Vaccine Information and was given a chance to ask questions and my questions were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I permit the person named above to be given the vaccine(s) as indicated above. I am the parent or legal guardian of this person.</p> <p>SIGNATURE of Parent/Guardian _____</p> <p>Please print name of parent _____</p>					1. Has your student ever had a serious reaction after receiving a vaccination?	Yes	No	2. Does your student have a chronic health condition that affects vaccination status?	Yes	No	3. Does your student take cortisone, prednisone, other steroids, or anti-cancer drugs?	Yes	No	4. During the past year, has your student received a blood transfusion or blood products?	Yes	No
1. Has your student ever had a serious reaction after receiving a vaccination?	Yes	No														
2. Does your student have a chronic health condition that affects vaccination status?	Yes	No														
3. Does your student take cortisone, prednisone, other steroids, or anti-cancer drugs?	Yes	No														
4. During the past year, has your student received a blood transfusion or blood products?	Yes	No														

School	Grade			
Date	Vaccine	Site	Lot #	Administered By
	Tdap			
	MCV4			

