

Vaccine Consent Form

You Must Complete All Sections Below to Participate in the School Based Vaccination Program

Name of School Student Attends:				Student's Grade			
Last Name		First Name		MI	DOB		Male Female
Street Address (include Apt # if applicable)				City		State	Zip
Parent/Guardian – Please PRINT Name			Daytime Phone Number		Cell Phone Number		
VACCINATION HISTORY OBTAIN INFORMATION FROM PHYSICIAN				PLEASE SIGN IF VACCINE IS NEEDED			
HEPATITIS B (3 shots) _____ Date Vac #1 Date Vac #2 Date Vac #3				HEPATITIS B: I have been provided a copy of the Hepatitis B Vaccine Information Statement and understand the benefits and risks of the vaccine. I understand that 3 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE HEPATITIS B VACCINE(S) Signature:			
MMR (2 shots) _____ Date Vac #1 Date Vac #2				MMR: I have been provided a copy of the Measles-Mumps-Rubella (MMR) Vaccine Information Statement and understand the benefits and risks of the vaccine. I understand that 2 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE MMR VACCINE(S) Signature:			
TDAP Td _____ Date Vaccine Date Vac #2				TDAP: I have been provided a copy of the Tetanus-Diphtheria-Pertussis (TDAP) Vaccine Information Statement and understand the benefits and risks of the vaccine. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE TDAP VACCINE Signature:			
MENINGITIS _____ Date Vac #1 Date Vac #2 Date Vac #3				MENINGITIS: I have been provided a copy of the Meningococcal (Meningitis) Vaccine Information Statement and understand the benefits and risks of the vaccine. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE MENINGITIS VACCINE Signature:			
CHICKENPOX _____ Date Vac #1 Date Vac #2 _____ Date Had Chickenpox				CHICKENPOX: I have been provided a copy of the Varicella (Chickenpox) Vaccine Information Statement and understand the benefits and risks of the vaccine. I understand that 2 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE VARICELLA VACCINE(S) Signature:			
POLIO (3-4 shots) _____ Date Vac #1 Date Vac #2 Date Vac #3 _____ Date Vac #4				POLIO: I have been provided a copy of the Polio Vaccine Information Statement and understand the benefits and risks of the vaccine. I understand that 3-4 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE POLIO VACCINE(S) Signature:			
HPV (3 shots) _____ Date Vac #1 Date Vac #2 Date Vac #3				HUMAN PAPILLOMAVIRUS VACCINE: I have been provided a copy of the HPV Vaccine Information Statement and understand the benefits and risks of the vaccine. I understand that 3 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE HPV VACCINE(S) Signature:			
HEPATITIS A (2 shots) _____ Date Vac #1 Date Vac #2				HEPATITIS A: I have been provided a copy of the Hepatitis A Vaccine Information Statement and understand the benefits and risks of the vaccine. I understand that 2 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE HEPATITIS A VACCINE(S) Signature:			

Revised 4-20-2011

I UNDERSTAND THAT BY TYPING MY NAME ON THE SIGNATURE LINE, I AM GIVING PERMISSION FOR MY CHILD TO RECEIVE THAT PARTICULAR VACCINE.

Please continue: Page 2 must be completed in order for your child to receive any of the above vaccines.



Student's Name _____

Name of School _____

IMMUNIZATION SCREENING QUESTIONNAIRE

Parent/Guardian: *Please check the answers to the questions below to help us determine which vaccines may be given.*

- | | | |
|--|-----|----|
| 1. Does your child have allergies to medications, food, or any vaccine?
If yes, please explain _____ | Yes | No |
| 2. Has your child ever had a serious reaction to a vaccine in the past?
If yes, to what vaccine and when? _____ | Yes | No |
| 3. Has your child ever had a seizure or brain problem?
If yes, please indicate current status: _____ | Yes | No |
| 4. Does your child have leukemia, AIDS, or any other immune system condition? | Yes | No |
| 5. Does your child take cortisone, prednisone, other steroids or anti-cancer drugs, or has he/she had an x-ray treatment in the past three months? | Yes | No |
| 6. Has your child received a blood transfusion, blood products, or been given a medicine called immune (gamma) globulin in the past year? | Yes | No |
| 7. Has your child received any vaccinations in the past 4 weeks?
If yes, which vaccine(s) _____ | Yes | No |

VBYG INSURANCE INFORMATION

Blue Cross & Blue Shield _____
(letters) (numbers)

Medicare Part B _____
(9 numbers) (letter)

Federal Blue Cross _____

TriCare _____

No Insurance

Other _____
(name of insurance) (your insurance id #)

Parent/Guardian Name

Daytime Phone Number