Jefferson County Public Health – Immunization Consent

For School-Based Health Clinics
Students age 11 through 18 years old

PARENTS MUST COMPLETE THIS SIDE FOR STUDENT

_____ ___/____/___ M / F
Patient First Name MI Last Name Client birthdate Gender

_____ ____/_____/_____
❖ PRINTED name of **Parent** or **Guardian** Parent/Guardian birthdate
❖ **(Parent or Guardian must also sign on reverse side for a patient under age 18)**

Mailing address:_____
Street City State Zip Code

Phone # (_____)_____

Ethnicity: Hispanic? Y / N

Race:

☐ American Indian or Alaskan Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian or other Pacific Islander
☐ White or Caucasian ☐ Other Race: _____

Has the patient:

Yes	No	Unsure	
☐	☐	☐	Experienced fever, vomiting, or diarrhea today?
☐	☐	☐	Received any other immunizations during the past month? If so, which?_____
☐	☐	☐	Had allergies to medications, eggs, yeast, gelatin, latex, or other foods or chemicals? List:_____
☐	☐	☐	Had a serious reaction or allergy to a vaccine in the past? If so, what?_____
☐	☐	☐	Had the chickenpox? Approximate date or age of disease: _____
☐	☐	☐	Does the patient or a family member have seizures, changing neurological disorder, or Guillain-Barre syndrome?
☐	☐	☐	Ever had thrombocytopenia (decreased platelets/increase bleeding)?
☐	☐	☐	Received blood, plasma, or immune globulin in the past six months?
☐	☐	☐	Have a bleeding disorder or take medications that increased bleeding?
☐	☐	☐	Is client pregnant or planning to be pregnant within the next month?
☐	☐	☐	Had a history of thymus disease, thymectomy, or intussusception?
☐	☐	☐	Does the patient or anyone in the home have: cancer, an immune disorder, a spleen removed, an organ transplant, or being treated with medications for rheumatoid, psoriasis, or autoimmune disease, or medications that suppress the immune system? Is the patient or anyone at home HIV positive?

JEFFERSON COUNTY PUBLIC HEALTH • 615 SHERIDAN • PORT TOWNSEND, WA 98368

Parent/Guardian - FILL IN YELLOW SECTIONS ONLY

STUDENT NAME:_____

Parent consents to vaccination (Initial each)	**Recommended** Vaccinations for this student:	VACCINE	NDC #	MANUFACTURER & LOT NUMBER	ROUTE/& SITE	DOSE
		POLIO - IPV	49281-860-78	SANOFI	IM:_____ SC:_____	0.5 cc
		HEPATITIS **A**	58160-0825-43 58160-0826-43	GSK MERCK	IM:_____	0.5 cc
		HEPATITIS **B**	58160-0820-43 58160-0821-43 0006-4981-01	GSK MERCK	IM:_____	0.5 cc
		MEASLES-MUMPS-RUBELLA (MMR)	0006-4681-01	MERCK	SC:_____	0.5 cc
		HUMAN PAPILLOMAVIRUS **(HPV9)**	0006-4119-03 0006-4121-01	MERCK	IM:_____	0.5cc
		MENACTRA - MENINGOCOCCAL (MCV4)	49281-0589-58	SANOFI	IM:_____	0.5 cc
		TETANUS/DIPHTHERIA,/PERTUSSIS Tdap_____ Td_____	58160-0842-01 58160-0842-43 49281-0400-58 49281-0215-58	GSK SANOFI	IM:_____	0.5 cc
		INFLUENZA (Flu)		MEDIM SANOFI	IM:_____ NAS:____	0.5 cc 0.2 cc

I have been given a copy and have read or had explained to me information in the Vaccine Information Statements for the diseases and the vaccines checked above. I had a chance to ask questions which were answered to my satisfaction. I understand the benefits & risks of the vaccines and request that the vaccines indicated above be given to me or the person named on the reverse side for whom I am authorized to make this request.

_____ _____

SIGNATURE OF PARENT / GUARDIAN IF CLIENT UNDER 18 **DATE**

_____ _____

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR **DATE**