



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: <input type="checkbox"/> Male Female Other	Race: African American Asian White American Indian/Alaskan Native		Ethnicity: Hispanic Non-Hispanic	

Please review vaccine record with personnel at the vaccination site, then select and initial the vaccine(s) you would like your child to receive.

TDAP (Requirement)	<input type="checkbox"/>	Initial:	HPV (1 st Dose)	<input type="checkbox"/>	Initial:
MEN ACWY	<input type="checkbox"/>	Initial:	Hepatitis A	<input type="checkbox"/>	Initial:

Medical screening questions for children and teens—required.

For parents/guardians: The following questions will help us determine which vaccines your child should 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
Does the child have allergies to medications, food, a vaccine component or latex?			
Yes:			
Has the child had 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(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 for any reason. Unless I sign a statement signifying otherwise, I will allow immunization information to be entered into the Florida Shots and be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status.

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

Clinic 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	