

SCHOOL IMMUNIZATION - CONSENT FORM

Please Print Clearly

FIRST NAME	<input style="width: 100%;" type="text"/>	Social Security Number (optional)	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
LAST NAME	<input style="width: 100%;" type="text"/>	DATE OF BIRTH	<input style="width: 100%;" type="text"/>			
Mother's Maiden NAME	<input style="width: 100%;" type="text"/>	Home Phone (Child)	<input style="width: 100%;" type="text"/>			
Mailing Address	<input style="width: 100%;" type="text"/>					
CITY	<input style="width: 100%;" type="text"/>	STATE	<input style="width: 100%;" type="text"/>	ZIP CODE	<input style="width: 100%;" type="text"/>	

Please fill circles COMPLETELY

<u>Sex</u>	<u>Ethnicity</u>	<u>Race</u>		
<input type="radio"/> Male	<input type="radio"/> Hispanic	<input type="radio"/> Native American	<input type="radio"/> Black or African-American	<input type="radio"/> Other
<input type="radio"/> Female	<input type="radio"/> Non-Hispanic	<input type="radio"/> Asian	<input type="radio"/> White	

I have been given and have read, or have had explained to me, the information in the 'Vaccine Information Statement(s)' for the disease(s) and vaccine(s) checked below. I understand the benefits and risks of the vaccines requested and also understand that I have the alternative to decline the vaccines. I ask that the vaccines signed for below be given to me or the person named for whom I am authorized to make this request. I understand that some immunizations are given in a series over a period of time and that by signing this form I agree that the immunizations marked below will be given, including those needed to complete a series. I agree to report any problems that arise, and direct any questions I may have to the School Nurse. I also understand that I may request from the School Nurse procedures on how to lawfully discontinue a series once begun. I agree to allow information on immunizations given to me or to the named person to be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. I also understand that my medical care provider may release this information to the state immunization registry (NMSIS) unless I sign a document indicating my refusal.

Client or parent/guardian signature: _____ Date: _____

FOR SCHOOL NURSE ONLY

Chart #	<input style="width: 100%;" type="text"/>	Date of Service	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
For children 0-18 years, check category that applies:					
<input type="radio"/> Native American	<input type="radio"/> Private insurance				
<input type="radio"/> Salud/Medicaid or CHIP	<input type="radio"/> Has no health insurance				

Vaccine:	<input type="radio"/> Hep B/3 dose series	<input type="radio"/> Influenza	<input type="radio"/> Rotavirus/2d	Lot #	<input style="width: 100%;" type="text"/>	Injection Site	<input style="width: 100%;" type="text"/>
<input type="radio"/> DTaP	<input type="radio"/> Hep B/2 dose series	<input type="radio"/> MCV4	<input type="radio"/> Rotavirus/3d	Manufacturer:	<input type="radio"/> Sanofi Pasteur	<input type="radio"/> Merck	<input type="radio"/> Medimmune
<input type="radio"/> DTaP-HepB-IPV (Pediatrix)	<input type="radio"/> HepB-Hib (Comvax)	<input type="radio"/> MMR	<input type="radio"/> Td		<input type="radio"/> GlaxoSmithkline	<input type="radio"/> Wyeth	<input type="radio"/> Other_____
<input type="radio"/> DTaP-IPV-Hib (Pentacel)	<input type="radio"/> Hib/4 dose series	<input type="radio"/> MMRV	<input type="radio"/> Tdap		<input type="radio"/> Varicella		
<input type="radio"/> DTaP-IPV (Kinrix)	<input type="radio"/> Hib/3 dose series	<input type="radio"/> PCV7	<input type="radio"/> Polio		<input type="radio"/> Other_____		
<input type="radio"/> Hep A	<input type="radio"/> HPV						

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