Conrad School-Based Health Center
201 Jackson Ave.
Wilmington, DE 19805

Date: _____ Child's Name: _____ DOB: _____

Dear Parent or Guardian:

Please check one vaccine box

☐ Diphtheria, Tetanus, Pertussis (Tdap)/Td ☐ Hepatitis B ☐ Human Papillomavirus (HPV)

☐ Meningococcal (MCV4) ☐ Meningococcal (Men B) ☐ Hepatitis A ☐MMR ☐IPV

☐Seasonal Flu OTHER: _____

Immunization guidelines have been established by the Division of Public Health to determine eligibility for students to receive vaccinations against some diseases through the School-Based Health Centers (SBHC). In order for your child to receive vaccinations through the SBHC, Please complete sections I and II.

Please note that the SBHC and the Division of Public Health believe the best way for your child to be vaccinated is through your Primary Health Care Provider (physician). Please sign the vaccine administration record on the back of this form to acknowledge you have received the vaccine information sheet.

SECTION I

I would like my child to be vaccinated at the SBHC due to the following:

1. ☐ Cannot get to the doctor for reasons such as costs, lack of transportation, missed time at school.
   Please write in your reason:_____
2. ☐ The next available appointment time with the doctor will prevent my child from meeting a deadline such as school entry or athletic activity.
3. ☐ My child does not have a family doctor or other health care provider. (Explain, we may be able to help)

_____

SECTION II (VFC Patient Eligibility Screening Record)

In addition to the item that I checked in Section I, my child **(check all that apply in Section II):**

4. ☐ Is age 18 or younger
5. ☐ Is enrolled in Medicaid.
6. ☐ Does not have health insurance.
7. ☐ Is an American Indian or Alaskan Native.
8. ☐ Is insured by **Delaware Healthy Children Program**
9. ☐ Is insured by **CHAP (Community Healthcare Access Program)**
10. ☐ Has other insurance that covers vaccinations.
    Please write in the name of the insurance:_____

☐ If your child has health insurance that does not pay for vaccinations you must go to one of the following centers:
Henrietta Johnson Medical Center, Wilmington (302) 655-6190
Westside Health Services, Wilmington (302) 655-5822

I agree that the above information is true and accurate. I have been given a copy of appropriate Centers for Disease Control & Prevention vaccine information materials and have read, or have had explained to me, information about the diseases and vaccine. I believe I understand the benefits and risks of the vaccines discussed as set forth in the materials I received and I consent to having the above vaccine given to my child. I understand that if my child is vaccinated in the SBHC, a record of his/her vaccinations will be sent to his/her family doctor if he/she has one.

Name of Doctor: _____

_____ _____
Signature of Parent/Guardian Date

Revised - 12/8/14

Vaccine Administration Record

PATIENT NAME: _____
DATE OF BIRTH: _____
PROVIDER NAME: _____
ADDRESS: _____
CITY, STATE, ZIP: _____

(Provider's stamp)

***SITE ROUTE LEGEND**
RA= *Right Arm*
LA= *Left Arm*
RT= *Right Thigh*
LT= *Left Thigh*
PO= *Oral*
IM= *Intramuscular*
SQ= *Subcutaneous*

CIRCLE VACCINE	DATE GIVEN M/D/Y	SITE/ ROUTE	VACCINE		VACCINE INFORMATION STATEMENT (VIS)		VACCINATOR (signature or initials & title)	PARENT/ GUARDIAN/ SIGNATURE/ DESIGNEE	VFC YES
			LOT#	MFR.	DATE ON VIS	DATE GIVEN			
DTaP DTaP/Hepb/IPV DT									
DTaP DTaP/Hepb/IPV DT									
DTaP DTaP/Hepb/IPV DT									
DTaP DT									
DTaP DTaP/IPV DT									
Hep A					7/20/2016				
Hep A									
Hep B					8/15/2019				
Hep B									
Hep B									
Hib HepB/Hib DTaP/Hib/IPV									
Hib HepB/Hib DTaP/Hib/IPV									
Hib HepB/Hib DTaP/Hib/IPV									
Hib DTaP/Hib/IPV									
HPV					12/02/2016				
HPV									
HPV									
Influenza					8/15/2019				
Influenza									
IPV					7/20/2016				
IPV									
IPV									
IPV									
Meningo Conj (MCV4)					8/15/2019				
Meningo Conj (MCV4)									
Meningitis B					8/15/2019				
Meningitis B									
MMR MMRV					8/15/2019				
MMR MMRV									
PCV 13									
PCV 13									
PCV 13									
PCV 13									
Td					4/11/2017				
Td Tdap					2/24/2015				
Varicella									
Varicella									
Other:									

DELAWARE HEALTH AND SOCIAL SERVICES **Division of Public Health Immunization Program 1-800-282-8672**

Revised 11/2011

VIS Dates Revised 12/2018