ChristianaCare

IMMUNRECORD

School-Based Health Centers (SBHC)

VACCINE ADMINISTRATION CONSENT

Please print clearly. **Date given:** _____

Child's name: _____ **Date of birth:** _____

We will send vaccination information from this visit to your child's doctor/primary care provider using the contact information provided below. Doctor/primary care provider name: _____

_____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP code:** _____

I want my child to receive the following vaccination(s):

- ☐ Hepatitis B vaccine - 3 dose series
- ☐ Hepatitis A vaccine - 2 dose series
- ☐ Measles-Mumps-Rubella (MMR) vaccine - 2 dose series
- ☐ Varicella - 2 dose series
- ☐ MMR/Varicella - 1 or 2 doses
- ☐ Tetanus, Diphtheria, and acellular Pertussis vaccine (Tdap)
- ☐ Human Papillomavirus vaccine (HPV) - 2 or 3 dose series, depending on age
- ☐ Meningococcal vaccine - 2 dose series
- ☐ Meningococcal B vaccine - 2 dose series
- ☐ Inactivated poliovirus vaccine (IPV) - multi dose series
- ☐ Influenza vaccine (FLU) - annual
- ☐ COVID-19 vaccine
- ☐ 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.

SECTION I (mark all that apply)

I would like my child to be vaccinated at the SBHC

☐ I cannot get my child to the doctor for reasons such as costs, lack of transportation, missed time at school.

Please write the reason: _____

☐ The next available appointment time with the doctor will prevent my child from meeting a deadline such as school entry or athletic activity.

☐ My child does not have a family doctor, pediatrician, or other regular health care provider. (Explain, we may be able to help) _____

_____

_____

SECTION II: Vaccines for Children Program Patient Eligibility Screening Record

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

- ☐ Is age 18 or younger.
- ☐ Does not have health insurance.
- ☐ Is insured by Delaware Healthy Children Program.
- ☐ Is enrolled in Medicaid.
- ☐ Is an American Indian or Alaskan Native.
- ☐ Is insured by CHAP (Community Healthcare Access Program).

Has other insurance that covers vaccinations, such as: _____

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I certify that I am either the patient and at least 18 years of age; the legal guardian of the patient; or a person authorized to consent on behalf of the patient. I hereby consent to ChristianaCare and the licensed healthcare professional (each an "applicable Provider") to administer the vaccine(s) I have requested above.

I understand that it is not possible to know all possible side effects or complications related to the vaccine(s). I certify that I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the CDC (Center for Disease Control and Prevention) Vaccine Information Statement (VIS) on the vaccine(s). I have been offered the opportunity to ask my doctor or provider any questions I have about the vaccine(s). My questions have been answered to my satisfaction. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from this treatment.

Further, I authorize the applicable Provider to: release my medical or other information, including any communicable disease (including HIV) and mental health information, to, or through, the State HIE, Government Agencies, Medicare, Medicaid, or other third-party payer as necessary to process care or payment; submit a claim to my insurer for the above requested items and services; and request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services.

Signature of Patient or Decision Maker	Relationship to Patient	Date	Time
		____/____/____	

Telephone Consent:

Name of person providing consent	Relationship to Patient if Decision Maker		

Witness Signature/Title	Print Name or ID#	Date	Time
		___/___/___	
		___/___/___	

Interpretation: The information has been presented to the: ☐ Patient ☐ Representative ☐ Decision Maker in: _____ (Language)
The person who provided the interpretation is a qualified medical interpreter.

Interpreter Name	Agency and ID# (if applicable)		

Witness Signature/Title	Print Name or ID#	Date	Time
		___/___/___	