



San Benito Consolidated Independent School District

240 N. Crockett St. • San Benito, TX 78586 • Phone: (956) 361-6150

San Benito CISD Vaccine Administration Consent

Name: _____
(Last name) (First name) (Middle name)

DOB: _____ **Student ID:** _____ **Sex (please circle):** M F Prefer not to answer

Address: _____
(Street) (City & State) (Zip code)

The following questions will help us determine which vaccines may be given today and should be answered for the person that is receiving the vaccine(s). If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means that we need to ask you more questions.	Yes	No
1. Are you sick today?	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (ex: diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak?	☐	☐
5. Are you on long-term aspirin therapy?	☐	☐
6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐
7. Do you have a parent, brother, or sister with an immune system problem?	☐	☐
8. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, or have you had radiation treatments?	☐	☐
9. Have you had a seizure? Or any other brain or nervous system problem?	☐	☐
10. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐	☐
11. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐
12. Are you pregnant?	☐	☐
13. Have you received any vaccines in the past 4 weeks?	☐	☐
14. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☐
15. Are you anxious about getting a shot today?	☐	☐

Questions reviewed by: _____
(SBCISD Health Services staff member)

Date: _____

Consent

I have read, or have had read to me, the written information regarding the vaccine(s) being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet. I, on behalf of myself and as parent and/or guardian, as applicable, hereby agree to release, indemnify, and hold harmless the San Benito CISD, its officers and its employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) on behalf of myself or in the capacity of a guardian and/or parent of the child to be vaccinated. I certify that I am at least 18 years old and hereby give my consent to the San Benito CISD Health Services Department (including RNs, LVNs and health aides) of San Benito CISD to administer the vaccine(s). If under 18 years old, parent or guardian signature is required.

Signature of person to receive vaccine (student must be 18 years old to sign) or person authorized to make the request (parent or guardian).

_____ Printed name

_____ Relationship

_____ Signature

_____ Date

SBCISD Health Services Dept. Staff use only								
Select which vaccines were administered	Vaccine & Manufacturer	Date of admin.	Lot	Exp. Date	Dose	Site of injection (please circle)	Date VIS was provided	Edition date of VIS
☐	Infanrix (DTaP)					RD LD RT LT		
☐	Kinrix (DTap-IPV)					RD LD RT LT		
☐	Havrix (Hep. A)					RD LD RT LT		
☐	Twinrix (Hep. A& B)					RD LD RT LT		
☐	Engerix (Hep. B)					RD LD RT LT		
☐	ActHIB (HIB)					RD LD RT LT		
☐	Gardasil (HPV)					RD LD RT LT		
☐	IPOL (IPV)					RD LD RT LT		
☐	MenQuadfi (MCV4)					RD LD RT LT		
☐	Bexsero (MenB)					RD LD RT LT		
☐	MMRII (MMR)					RD LD RT LT		
☐	ProQuad (MMRV)					RD LD RT LT		
☐	Prevnar (PCV)					RD LD RT LT		
☐	Adacel (Tdap)					RD LD RT LT		
☐	Boostrix (Tdap)					RD LD RT LT		
☐	Varivax (Varicella)					RD LD RT LT		

Location where vaccines were administered: _____

Name and title of person who administered vaccine: _____