

IMMUNIZATION PARENT CONSENT FORM

STUDENT INFORMATION (USE BLACK INK ONLY)

STUDENT FIRST NAME		MI	STUDENT LAST NAME		AGE	GRADE
DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	SCHOOL		HOMEROOM TEACHER		
RACE <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White				ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		
STREET ADDRESS			CITY	STATE	ZIP	
PARENT/GUARDIAN FIRST NAME		PARENT/GUARDIAN LAST NAME		PARENT/GUARDIAN CELL PHONE () -		
PARENT/GUARDIAN EMAIL ADDRESS				PARENT/GUARDIAN HOME PHONE () -		

INSURANCE INFORMATION (PLEASE FILL OUT COMPLETELY)

MEDICAID <input type="checkbox"/> Yes (Enter Medicaid Number) <input type="checkbox"/> No (Continue completing form)	SC MEDICAID NUMBER
INSURANCE <input type="checkbox"/> Yes (Enter insurance information) <input type="checkbox"/> No (Skip to screening questions)	VACCINE COVERED <input type="checkbox"/> Yes <input type="checkbox"/> No

Check the vaccine you would like your child to receive: Tdap (required) Varicella (required) Hepatitis B (required) Meningitis (recommended)
 HPV (recommended) Hepatitis A (recommended) Polio Flu MMR DTaP

VACCINE SCREENING QUESTIONS

PLEASE ANSWER ALL QUESTIONS BELOW:

1. Has your child had any health conditions or major illnesses, such as heart disease, diabetes, asthma or thrombocytopenia? If yes, please list:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does your child have allergies to latex, medications, food or vaccines (examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, Neomycin, phenol, yeast or thimerosal)? If yes, please list:	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has your child ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has your child ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre syndrome (a condition that causes paralysis) or other nervous system problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. For women: Are you pregnant or considering becoming pregnant in the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For chickenpox, MMR-11, only: Only answer the following questions if you are receiving any vaccinations listed above.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has your child received any vaccinations or skin tests in the past four to eight weeks? If yes, please list:	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Does your child have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is your child currently on any medications? If yes, please list medicine:	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Is your child currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has your child received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Would you like a paper copy of the Vaccine Information Sheet sent home with your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No

AUTHORIZATION, CONSENT AND RELEASE

I voluntarily request and consent for the Charleston County School District (CCSD) to provide the above selected vaccines for my child named on this form. I also, consent for my child to receive these vaccines at school, to be administered by CCSD nursing staff. I have been provided the Vaccine Information Statements. These can also be found at www.cdc.gov/vaccines/hcp/vis/current-vis.html. I have had an opportunity to ask questions about the vaccines. I understand the risks and benefits of the vaccines. I understand that the vaccines will be given as a shot. I have read and answered the questions above carefully and accurately, and I understand that incorrect information could cause serious risks to my child. In case of occupational exposure, I consent to my child's blood testing if necessary for child and employee safety. I understand that immunization information about my child will be reported to SC Immunization Registry for public health purposes. I hereby RELEASE AND HOLD HARMLESS CCSD, its employees, trustees, and/or agents ("Releasees") from any and all liability, claims, demands and causes of action of whatever kind or nature, either in law or equity, which may arise as a result of receiving the requested vaccines, including claims of bodily and/or mental injury, illness, or death, whether caused by the negligence of Releasees or otherwise.

I further consent to CCSD releasing and exchanging information about the service provided along with my child's name, date of birth, Medicaid or health insurance number, gender, as well as my contact information to the Medicaid Agency (Department of Health and Human Services); and for CCSD to bill and receive payment for the services described herein from the Medicaid Agency. I understand that Medicaid reimbursement for Non-IEP nursing services provided by CCSD will not affect any other Medicaid services for which my child is eligible. CCSD will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) to ensure confidentiality regarding my child's treatment and provision of Non-IEP nursing services.

I have read the above Consent, Authorization and Release and understand its provisions and applicability and have been given the option and recommendation of consulting with my own personal physician. I understand that participating in the vaccination program is totally voluntary and that my child is not required to participate. I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

SIGNATURE OF PARENT OR LEGAL GUARDIAN	DATE
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