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	SCHOOL	HOMEROOM TEACHER
	☐ Male ☐ Female		«Teacher»

RACE ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White

ETHNICITY ☐ Hispanic or Latino ☐ 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	☐ Yes (Enter Medicaid Number) ☐ No (Continue completing form)	SC MEDICAID NUMBER
INSURANCE	☐ Yes (Enter insurance information) ☐ No (Skip to screening questions)	VACCINE COVERED ☐ Yes ☐ 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 orthrombocytopenia? If yes, please list:	☐ Yes ☐ 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:	☐ Yes ☐ No
3. Has your child ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ Yes ☐ 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?	☐ Yes ☐ No
5. **For women:** Are you pregnant or considering becoming pregnant in the next month?	☐ Yes ☐ No
For chickenpox, MMR•11, only: Only answer the following questions if you are receiving any vaccinations listed above.	☐ Yes ☐ No
6. Has your child received any vaccinations or skin tests in the past four to eight weeks? If yes, please list:	☐ Yes ☐ No
7. Does your child have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	☐ Yes ☐ No
8. Is your child currently on any medications? If yes, please list medicine:	☐ Yes ☐ No
9. Is your child currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than 2 weeks?	☐ Yes ☐ 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?	☐ Yes ☐ No
11. Would you like a paper copy of the Vaccine Information Sheet sent home with your child?	☐ Yes ☐ 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 and 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

VACCINE ADMINISTRATION DOCUMENTATION
(CLINIC USE ONLY)

VACCINE HISTORY

Documentation	Nurse's Initials	Comments
No Contraindications or Precautions		
No Allergies		
Previous Doses (if applicable)		
Not pregnant (if female)		

VACCINE ELIGIBILITY

Eligibility Code	Eligibility Category	Eligibility Check	Comments
1	Pediatric VFC> Medicaid		
2	Pediatric VFC>AA/AN		
3	Pediatric VFC> No Health Insurance		
4	Pediatric State > Underinsured/Hardship		
5			

DOCUMENTATION

Vaccine Name	Dosage	Dose #	Site	Route	Manufacturer	Lot #	VIS	Elig
Tdap	0.5ml			IM	Sanofi		08/06/2021	
Varicella	0.5 ml			SQ	Merck		08/06/2021	
MMR	0.5 ml			SQ	Merck		08/06/2021	
Hepatitis B	0.5ml			IM	GSK		10/15/2021	
Meningococcal- Menactra	0.5 ml			IM	Sanofi		08/06/2021	
HPV-9	0.5ml			IM	Merck		08/06/2021	
Hepatitis A	0.5 ml			IM	GSK		10/15/2021	
Influenza (IIV4)	0.5 ml			IM	GSK		08/06/2021	
Influenza (LAIV4)	0.5 ml			Nasal	MI		08/06/2021	
IPV					Sanofi		08/06/2021	
DTaP				IM	GSK		08/06/2021	
Pediarix				IM	GSK		08/06/2021	
Kinrix				IM	GSK		08/06/2021	
MMRV				SQ	Merck		08/06/2021	

SIGNATURE/TITLE PERSON ADMINISTERING VACCINE	DATE
CLINIC SITE	IIS ENTRY COMPLETE ☐