

CHESTER COUNTY HEALTH DEPARTMENT VACCINE CONSENT FORM

SCHOOL _____

DISTRICT _____

NAME:	Male / Female
ADDRESS:	
	DOB:
	Age:

Telephone # _____	Grade _____
Home: _____	
Work: _____	

Type of Insurance:	Private Insurance	No Insurance
Race:	White	African American
	Asian/Pacific Islander	Asia Indian
	Other: _____	
Ethnicity:	Hispanic	Non Hispanic
	Unknown	

Sign by (✓) for each vaccine you WANT your child to have.

VACCINE		PARENT SIGNATURE
DTaP		
Hepatitis B		
Polio booster		
MMR (Measles, Mumps, & Rubella)		
Meningococcal Conjugate		
Td		
Tdap		
Varicella		

Please answer the following questions about your child:

Please Circle

- | | | |
|--|-----|----|
| 1. Is your child in good health?
If no, please explain _____ | YES | NO |
| 2. Is your child allergic to yeast, gelatin, neomycin, streptomycin, polymyxin B, thimerisol, or latex? If yes, please explain _____ | YES | NO |
| 3. Has your child ever had a serious reaction (e.g. hives, breathing problem, collapse, etc.) to any previous immunizations?
If yes, please explain _____ | YES | NO |
| 4. Is there a history of seizures in the family (child, parents, or siblings)?
If yes, please explain _____ | YES | NO |
| 5. Has your child had a blood transfusion and/or gamma globulin in the past 12 months?
If yes, please explain _____ | YES | NO |
| 6. Is your child or anyone in the immediate household immunocomprised (cannot fight disease for any reason such as taking high doses of steroids, chemotherapy, AIDS, is on kidney dialysis or had an organ transplant)?
If yes, please explain _____ | YES | NO |

I have been given a copy and have read the information contained in the attached Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. **I believe I understand the benefits and the risks of the vaccine(s) and request that the vaccine(s) indicated above be given to the person named for whom I am authorized to make this request.** As parent and/or guardian of the minor child mentioned above, I hereby authorize the release of the medical immunization record only, past and present, of said minor for the purposes of inclusion in the Health Department immunization tracking system, provided that said information shall at all times be held in confidence, excepting the Health Department and the designated health care provider or insurer. If you have any questions please call Sandra Schwartz, MSN., RN. at the Chester County Health Department (610)344-5562 or 1-800-692-1100 ext. 5562

SIGNATURE _____

Date _____

Name: _____

DOB _____

FOR HEALTH DEPARTMENT USE ONLY

DATE						
1. PERMISSION SIGNED						
2. HEALTH STATEMENT REVIEWED						
NURSES INITIALS						

DTaP
 Clinic site: _____ Date _____
 Manufacturer/Lot Number _____ Exp. Date _____
 Site of Injection: R or L (Deltoid) Route: IM VIS Date 5/17/07
 Signature & Title of vaccine administrator: _____

HEPATITIS B
 Clinic site: _____ Date _____
 Manufacturer/Lot Number _____ Exp. Date _____
 Site of Injection: R or L (Deltoid) Route: IM VIS Date 7/18/07
 Signature & Title of vaccine administrator: _____

IPV # _____
 Clinic site: _____ Date _____
 Manufacturer/Lot Number _____ Exp. Date _____
 Site of Injection: R or L (Upper Arm) Route: SQ VIS Date 1/1/00
 Signature & Title of vaccine administrator: _____

MMR
 Clinic site: _____ Date _____
 Manufacturer/Lot Number _____ Exp. Date _____
 Site of Injection: R or L (Upper Arm) Route: SQ VIS Date: 3/13/08
 Signature & Title of vaccine administrator: _____

Meningococcal Conjugate
 Clinic site: _____ Date _____
 Manufacturer/Lot Number _____ Exp. Date _____
 Site of Injection: R or L (Deltoid) Route: IM VIS Date 1/28/08
 Signature & Title of vaccine administrator: _____

Td / Tdap
 Clinic site: _____ Date _____
 Manufacturer/Lot Number _____ Exp. Date _____
 Site of Injection: R or L (Deltoid) Route: IM VIS Date: 11/18/08
 Signature & Title of vaccine administrator: _____

Varicella
 Clinic site: _____ Date _____
 Manufacturer/Lot Number _____ Exp. Date _____
 Site of Injection: R or L (Upper Arm) Route: SQ VIS Date: 3/13/08
 Signature & Title of vaccine administrator: _____

 Clinic site: _____ Date _____
 Manufacturer/Lot Number _____ Exp. Date _____
 Site of Injection: R or L (Deltoid / Upper Arm) Route: IM / SQ VIS Date: _____
 Signature & Title of vaccine administrator: _____