Vaccinate before you Graduate

VACCINE CONSENT FORM

RHODE ISLAND DEPARTMENT OF HEALTH

PERSONAL INFORMATION School Student Attends:			Year of Graduation:
Print Student Name Last:	First:	☐ Male ☐ Female	Date of Birth: _____/_____/_____
Street Address:	City:	St:	Zip:
Print Parent/Guardian Name:			Daytime Phone #:

HEALTH INSURANCE INFORMATION

Name of Insurance Company: _____

Member Id: _____ Group # (if applicable): _____

☐ No Insurance

MEDICAL SCREENING FOR VACCINE ELIGIBILITY

1. Does your child have allergies to medications, food, or any vaccine? Y / N If yes, list: _____
2. Has your child ever had a serious reaction to a vaccine in the past? Y / N If yes, explain: _____
3. Has your child, a sibling, or a parent ever had a seizure or brain problem? Y / N
4. Does your child have cancer, leukemia, HIV/AIDS, or any other immune system condition? Y / N
5. Does your child take cortisone, prednisone, steroids or anti-cancer drugs or had radiation treatment? Y / N
6. Received a blood transfusion, blood products, or been given immune (gamma) globulin in the past year? Y / N
7. Has your child received any vaccinations in the past 4 wks or taken an antiviral drug? Y / N If Y, List:_____

CONSENT FOR VACCINATION IN SCHOOL SETTING

I have viewed the Vaccine Information Statement(s) for the vaccine(s) requested at http://www.immunize.org or obtained a hard copy by calling the Rhode Island Department of Health at 401-222-5960. I understand the benefits and risks of the vaccine(s) requested.

I understand that a record of vaccinations administered in this program will be submitted to the statewide database, KIDSNET within 48 hrs of vaccination. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine.

PARENT SIGNATURE REQUIRED NEXT TO EACH VACCINE REQUESTED:

Vaccination History
List Dates If Available

HEP A	_____	**DATE:**_____	DOSE #1_____#2 _____
HEP B	_____	**DATE:**_____	DOSE #1_____ #2 _____ #3_____
HPV	_____	**DATE:**_____	DOSE #1_____ #2_____ #3 _____
MMR	_____	**DATE:**_____	DOSE #1_____ #2 _____
MENINGITIS (MCV4)	_____	**DATE:**_____	DOSE #1_____ #2 _____ #3_____
MENING B	_____	**DATE:**_____	DOSE #1_____ #2 _____ #3_____
POLIO	_____	**DATE:**_____	DOSE #1 _____ #2 _____ #3 _____
TDAP / TD	_____	**DATE:**_____	DOSE# : _____ TD: _____ TD: _____
CHICKEN POX	_____	**DATE:**_____	DOSE #1 _____ #2_____ DATE DX:_____

The vaccine(s) checked should be given to the student named for whom I am authorized to make this request. I understand that all doses indicated for each vaccine are needed to receive full protection.

RETURN THIS FORM TO YOUR SCHOOL NURSE