SCHOOL IMMUNIZATION RECORD – CONSENT FORM

Parents must complete sections A, B and sign at the X's in section C. If incomplete, immunizations will not be given.

I have been given a copy and have read, or have had explained to me, the information in the *Vaccine Information Statement(s)* for the disease(s) and vaccine(s) circled below. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) circled below be given to me or to the person named below for whom I am authorized to make this request.

Hepatitis A Hepatitis B Td DTaP Polio Measles-Mumps-Rubella Varicella

If your child has already received the vaccine(s) indicated above, please fill in the dates the vaccine(s) was received or send a copy of the shot record, so that your child's school immunization record can be updated.

SECTION A:

Child's Last Name	First	Middle	Date of Birth	Age	Sex M F	**Race:** O - Other, I - Native, A - Asian, W - White, B - Black; **Ethnicity**: H - Hispanic, N - NonHispanic
Address				Social Security # (optional)		
				Mother's Maiden Name		
City	State	Zip Code		Telephone Number		

SECTION B:

For children <19 years old, you must check one of the following categories: (Check only one - Native American takes priority)

☐ Is Native American =1 ☐ Has Private Health Insurance =3

☐ Is on Medicaid/SALUD/CHIP =2 ☐ Has No Health Insurance =4

SECTION C:

I understand that some shots are given in a series over a period of time and that by signing this form I agree that the shots marked above will be given, including those needed to complete a series. I agree to report any problems that arise, and direct any questions I may have to the School Nurse. I also understand that I may request from the School Nurse procedures on how to lawfully discontinue a series once begun.

Signature of Parent or Guardian: X **Date:**

I agree to allow information about all vaccinations given to me or to the person for whom I am authorized to consent to be released to other medical care providers to avoid the administration of unnecessary vaccinations and to ascertain immunization status. I understand that I am not required to agree to the release of this information to other healthcare providers in order to receive the vaccinations I request.

Signature of Parent or Guardian: X **Date:**

VACCINE	Dose	#	Manufacturer and Lot #	Site of Injection	Date	Signature and Title
Hepatitis B	1cc .5cc	1				
Please circle	1cc .5cc	2				
Dosage in cc's	.5cc	3				
DTaP Td		1				
		2				
		3				
		4				
IPV		1				
		2				
		3				
		4				
MMR		1				
		2				
Varicella		1				
		2				
Hepatitis A		1				
		2				

VFC SCHOOLS:
Enter VFC PIN #: _____
Please send a copy of all consent forms to:
NM Vaccines for Children Program
P.O. Box 26110
Santa Fe, NM 87502-6110

NON VFC SCHOOLS (Vaccine comes from local public health office):

Please provide health office with copies of all consent forms. Health Office will either enter forms into their data system or send them to the NM VFC program in Santa Fe.

5-17-01