SALEM HIGH SCHOOL

1400 TIGER PRIDE DRIVE Phone

Phone (573) 729-6641 Fax (573)729-7408

Child Immunization Consent Form

|  |  |  |  |
| --- | --- | --- | --- |
| Student Name | Age | Date of Birth | Grade |

|  |
| --- |
| School |

According to our school records, it is time for the above person to receive the MO state required vaccine(s) checked off below:

\_\_\_ MenQuadfi, Meningococcal (conjugate); This is required for all students going into the 8th & 12th grades.

\_\_\_ Tdap- Tetanus, diphtheria, acellular pertussis; This is required for all students going into the 8th grade. (booster every 10yrs)

**Recommended:**

\_\_\_ MenB, age 16-23yr (2 doses, 1 month apart)

\_\_\_ HPV, ages 9+ yr (2-3 doses)

\_\_\_ Other: COVID 19: Pfizer Moderna

Please read carefully. If you have any questions, call your area public health office: Dent Co Health Center 573-729-3106

A public health nurse will provide this immunization on: Date: **Thursday May 11, 2023 9-11:30 am**

**\*\* Parent or legal decision-maker to complete: \*\***

1. Does your child have any allergies? No ■ Yes ■ (If yes, please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Does your child have any health conditions that require regular visits to a doctor? No ■ Yes ■ (If yes, please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Has your child ever had chickenpox? No ■ Yes ■ Year: \_\_\_\_\_\_\_\_\_\_\_

4. Has your child ever had chickenpox vaccine? No ■ Yes ■ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Has your child ever had a reaction to a vaccine? No ■ Yes ■ (If yes, please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Is your child pregnant?(circle one) No Yes N/A

Check one of the following three options:

|  |
| --- |
| Yes, I would like my child to receive these immunizations. |
| Yes, I would like my child to receive these immunizations except: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  (Please mark which vaccine(s) that you do not consent to). |

|  |
| --- |
| No, I would not like my child to receive these immunizations. |
|  |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_/\_\_/\_\_

Telephone number: (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IMPORTANT: Please return this form completed and signed to the school or public health nurse by: \_\_\_\_\_\_\_\_\_\_\_\_\_

\*\* **Section to be completed by the immunization provider: DCHC\*\***

Name of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHIN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verbal Consent: The parent or legal decision-maker has been made aware of the benefits and the risks of the vaccine(s) offered to the above person and consents for the child to be immunized on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The parent or legal decision-maker has agreed to complete the Child Immunization Consent Form provided to him/her and has agreed to forward it to this immunization provider.

Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_