Cahaba Medical Care

VACCINE CONSENT FORM

Please circle the vaccines you consent for your child to receive:

TDAP **Meningococcal** **HPV**

Please complete ALL of the information below (INCOMPLETE FORMS WILL NOT BE ACCEPTED) **Please print using ink**

FIRST NAME of Student:	**LAST NAME of Student:**
Gender: Male Female **Birthdate:** (month, day, year)	**Age** **School / Homeroom Teacher / Grade**
Address	**Home Phone # ( ) -** **Cell Phone # ( ) -**
City **Zip Code** **State**	**Student Race:** (Circle one) African American / Black White Alaskan/ Native American Asian Hispanic Non-Hispanic Hawaiian / Pacific Islander Other :
Email address:	

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you, even if your child has no insurance coverage. Answers are always confidential.

Please fill out the following questions pertaining to your child's health insurance:

Insurance ☐ **Medicaid** ☐ **My child does NOT have health insurance** ☐	**Insurance Company:**
Policy Holder's First Name:	**Policy Holder's Last Name:**
Member ID:	**Policy Holder's Date of Birth: (month/day/year)**

CHECK YES OR NO FOR **EACH** QUESTION

YES	NO	
☐	☐	1. Has your child ever had a life threatening reaction(s) after a previous dose of any diphtheria, tetanus or pertussis containing vaccine?
☐	☐	2. Has your child ever had a life-threatening allergic reaction after a previous dose of meningococcal ACWY vaccine?
☐	☐	3. Has your child ever had a condition called Guillain Barré Syndrome (GBS)?
☐	☐	4. Has your child ever had seizures or another nervous system problem?
☐	☐	5. Has your child ever had a life threatening reaction(s) after a previous dose of Gardasil?
☐	☐	6. If applicable, is the student pregnant or nursing?

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT CAHABA MEDICAL CARE SCHOOL BASED HEALTH CLINIC.

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and have legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release the school system, Cahaba Medical Care & subsidiaries, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for six (6) months and that I will make the school aware of any health changes prior to the vaccination clinic date. Clinic dates can be obtained from the school. I understand that the health related information on this form will be used for insurance billing purposes and that my privacy will be protected.

Printed Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

TDAP	**MCV**	**HPV**
Lot #: **Exp. Date:**	**Lot #:** **Exp. Date:**	**Lot #:** **Exp. Date:**
Initials: **Date:**	**Initials:** **Date:**	**Initials:** **Date:**

CAHABA MEDICAL CARE SCHOOL BASED HEALTH CLINICS:

Brent Elementary School - 205.928.6045 **West Blocton Elementary School - 205.928.6046**