SCHOOL IMMUNIZATION CONSENT FORM

Form must be filled in completely and legibly

FOR SCHOOL OFFICE USE:
PLACE STICKER OR STAMP WITH SCHOOL ADDRESS HERE

Student's last name: ______________________ First name: ______________________ Middle name: ______________________

Mailing address: ______________________ (STREET ADDRESS) ______________________ (CITY) Zip: ____________ Daytime phone: ______________________

Date of Birth: ______________ (MONTH / DAY / YEAR) Age: ________ Mother's maiden name: ______________________ (FIRST NAME AND LAST NAME)

School name: ______________________ Grade: ________ Teacher: ______________________ Student ID#: ______________________

Race: ☐ White ☐ American Indian/Native American/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other	**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic	**Gender:** ☐ Male ☐ Female

INSURANCE INFORMATION—fill in appropriate category—REQUIRED

Centennial Care/Medicaid	Private/commercial insurance
☐ Blue Cross Blue Shield ☐ Molina Healthcare	☐ Blue Cross Blue Shield ☐ Presbyterian ☐ United Healthcare
☐ United Healthcare ☐ Presbyterian	☐ Other insurance ______________________ (NAME OF INSURANCE COMPANY)
Centennial Care (Medicaid) # ______________	Group # ______________ Policy/Member/ID # ______________
Member ID/Patient/Policy # ______________	Responsible party ______________________
☐ **My child does not have health insurance**	Policyholder's date of birth ______________________

CONSENT FOR CHILD'S VACCINATION IN SCHOOL

I have read or had explained to me the information in the Vaccine Information Statement (VIS) for the disease(s) and vaccines that I have selected for my child on the attached letter. I understand the benefits and risks of each vaccine and consent that the vaccines I have selected be given to the above named child. I understand that some vaccines are given in a series over a period of time and that by signing this form I consent to all the vaccines including those needed to complete a series. **I will contact the school nurse to withdraw this consent if my child is immunized before the date of the school clinic** or for any other reason. Unless I sign a statement signifying otherwise, I allow immunization information to be entered into the New Mexico Statewide Immunization Information System (NMSIIS) and be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. The Revised DOH Privacy Policy is available at http://nmhealth.org/help/privacy/ and will be provided to all students when they receive an immunization.

Signature of parent/legal guardian: ______________________ **Date:** ______________

Print name of parent/legal guardian (print legibly in all capitals): ______________________

FOR CLINIC USE ONLY—THIS SECTION TO BE COMPLETED BY MEDICAL PROVIDER

VFC PIN#

The following block is printed six times (in two columns of three):

Vaccine		**Manufacturer**	
☐ DTaP #___	☐ Men B #___	☐ GSK	Date ________
☐ DTaP-IPV	☐ MMR #___	☐ MedImmune	Lot # ________
☐ HepA #___	☐ PCV #___	☐ Merck	Exp. date ________
☐ Hep B #___	☐ Polio #___	☐ Pfizer	Injection site: ________
☐ Hib #___	☐ Rotavirus #___	☐ Sanofi Pasteur	VIS date ________
☐ HPV #___	☐ Tdap		
☐ Influenza	☐ Varicella #___		
☐ MCV4 #___	☐ Other:		

VACCINATOR SIGNATURE AND CREDENTIALS

RA/IM (Right Arm/Intramuscular) LA/IM (Left Arm/Intramuscular) RA/SC (Right Arm/Subcutaneous) LA/SC (Left Arm/Subcutaneous) IN (Intranasal)

Updated 9/30/16