School Immunization Consent Form

Name of School: _____

Student: _____ DOB: ____/____/_____

Address: _____
City State Zip

Phone: _____ **Student's physician:** _____

PLEASE CHECK ALL THAT APPLY:

☐ Medicaid ☐ Insured ☐ Wyoming Resident
☐ Uninsure ☐ Underinsured ☐ Male
☐ American Indian/Alaska Native ☐ Female

PLEASE ANSWER THESE QUESTIONS:

	Yes	No	Unsure
1. Is the student sick?	☐	☐	☐
2. Does the student have allergies to medications, food, a vaccine component, or latex? If yes, please list:_____	☐	☐	☐
3. Has the student had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the student have lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. Has the student, a sibling, or a parent had a seizure; has the child had brain or nervous system problems?	☐	☐	☐
6. Does the student have cancer, leukemia, HIV/AIDS, or any other immune system problems?	☐	☐	☐
7. Does the student have a parent, brother, or sister with an immune system problem?	☐	☐	☐
8. In the past 3 months, has the student taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
9. In the past year, has the student received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. Is the student pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
11. Has the student received vaccinations in the past 4 weeks?	☐	☐	☐

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Please explain any "yes" answers:

_____

_____

Parent Consent: Please initial next to each vaccine you would like your student to receive **Initial Below**		OFFICE USE ONLY			
		Date of Immunization	**Vaccine Administrator**	**Site**	**Manufacturer/Lot #/ Expiration**
	Tetanus/Diphtheria/Pertussis (Tdap) (1 booster dose)				
	Human Papillomavirus (HPV) (2-3 doses)	#1			
		#2			
		#3			
	Influenza (Flu)				
	Meningococcal ACWY				
	Meningococcal B				
	Other:				
	Other:				

I have been given a copy, and have read, or have had explained to me, the information in the "Vaccine Information Statements" for each vaccine listed below.
I understand the benefits and risks of each vaccine requested and ask that the vaccine(s) checked above be given to the student identified above, for whom I am authorized to make this request.
I understand that certain vaccines are required for school attendance, unless an exemption has been granted by the Wyoming Department of Health.

Print Parent/Guardian Name: _____**Relationship:**_____

Signature of Parent/Guardian: _____**Date:**_____

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Acknowledgement of Receipt of Notice of Privacy Practices

I have received and read the Wyoming Department of Health Notice of Privacy Practices and have had a chance to ask questions about how my information will be used. **Parent/Guardian initials**_____

INSURANCE INFORMATION

(Subscriber is the name of the person the insurance is under, i.e., the parent)

Primary Insurance: _____
Subscriber's Name: _____ DOB: _____
Group No: _____
Policy No: _____
Patient's relationship to subscriber: _____

Secondary Insurance: _____
Subscriber's Name: _____ DOB: _____
Group No: _____
Policy No: _____
Patient's relationship to subscriber: _____

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company or employer. I authorize my insurance benefits be paid directly to_____ County Public Health. I understand that I am financially responsible for any balance. I also authorize _____County or insurance company to release any information required to process my claims.

Parent/Guardian Signature _____Date_____