MYRTUE Medical Center

2018 CONSENT FOR SCHOOL ATHLETIC PHYSICAL IMMUNIZATIONS

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

Date of birth: _____ Age: _____ Allergies (if any): _____ School: _____

Address: _____ City: _____ IA Zip: _____

Parent name: _____ Maiden name of student's mother: _____

Parent's phone #: _____ Parent's other phone #: _____

Please mark with an X the vaccine eligibility status below that applies to your student:

These first four indicate eligibility for VFC (federally-funded vaccine) and no payment is due for vaccines.

_____ Is enrolled in Medicaid.
_____ Has health insurance that does NOT pay for any of the cost of vaccine coverage.
_____ Does not have health insurance of any kind.
_____ Is American Indian or Alaskan Native origin.

OR:

_____ Has health insurance that pays for all of or part of the cost for vaccine. (Please check with your insurance company first regarding coverage.) If yes, this vaccine that may be subject to co-payment & deductible.

I have received the vaccine information sheet(s) about the disease and vaccine regarding Hepatitis A, Meningococcal Quad and Meningococcal B (meningitis), Tetanus/Diphtheria/Pertussis (Tdap), and Human Papilloma Virus (HPV) vaccines. I have had an opportunity to ask questions about the vaccines. I understand the benefits and risks of this/these vaccination(s). I understand that my daughter/son needs: 2 doses of Hepatitis A vaccine, 1 dose of Tdap, 2 doses of Quadrivalent Meningococcal, 2 doses of Meningococcal B vaccine for 16-18 years old, and 2 - 3 doses of Human Papillomavirus vaccine (depending on age the vaccine was initiated) to obtain immunity from the infections and cancers that they prevent. However, as with all medical treatments, there is no guarantee that she/he will become immune or that she/he will not experience side effects of the vaccine.

I consent for my child to receive the following vaccines as per CDC/IDPH recommendations:
Tdap – Meningococcal MCV4---Meningitis B (age 16-18 only) - Hepatitis A – HPV
(Please cross through any recommended vaccines above that you do NOT want given to your child.)

For _____ **Signed:** _____ **Date:** _____
(Print student name) (Parent/guardian signature) (Date signed)

Nurse to complete below:

Date of Vaccination	Vaccine Type / Name Manufacturer / Lot # or sticker	Site of Vaccination Circle	Administered by	VIS Date
	Tdap SP# GSK#	0.5cc IM R or L deltoid		2.24.15
	Menactra SP #	0.5cc IM R or L deltoid		3.31.16
	Hep A GSK#	0.5cc IM R or L deltoid		7.20.16
	Gardasil Merck#	0.5cc IM R or L deltoid		12.2.16
	Bexsero brand Meningitis B GSK#	0.5 cc IM R or L deltoid		8.9.16