MINNEAPOLIS SCHOOL BASED CLINICS program

Vaccine Administration Consent
No Cost to You

Minneapolis Health

Explanation of Procedure

The Minneapolis Health Department School Based Clinics Program keeps this record in your medical file (or your child's medical file). The information contained within this record is being maintained to monitor immunization needs in order to prevent disease. If personal information is requested and not provided, immunization services may be denied. This information is private and will not be shared with anyone except the Minnesota Department of Health; licensed health care professionals such as doctors, nurses, health insurers, Head Start programs, schools, county public health agencies, community action agencies, or licensed health care facilities such as hospitals in order to assess and/or provide immunization services or to facilitate future enrollment in a school, or college. Your immunization records will be given to Minnesota Immunization Information Connection (MIIC) a statewide registry, for this purpose. If you choose not to have this information included in the registry please let us know.

Vaccine Administration

Many vaccines require two (2), three (3), four (4), or five (5) doses to provide complete protection. These include **Td** (tetanus/diphtheria); **Tdap** (tetanus, diphtheria, acellular pertussis): **IPV** (injectable polio vaccine); **MMR** (measles, mumps, rubella); **Hep B** (hepatitis B vaccine); **MCV4** (meningococcal conjugate vaccine); **HPV** (human papillomavirus); **Hep A** (hepatitis A vaccine); **MenB** (meningococcal group B vaccine); **COVID** (coronavirus disease vaccine); **Varicella** (varicella (chickenpox) vaccine), **MMRV** (measles, mumps, rubella, varicella); **DTaP** (diphtheria, tetanus, acellular pertussis); **MenABCWY** (meningococcal conjugate vaccine).

The following vaccine doses are being recommended by the medical provider:

Hep A: ❑ 1 ❑ 2 **Hep B:** ❑ 1 ❑ 2 ❑ 3 **HPV:** ❑ 1 ❑ 2 ❑ 3 **Influenza:** ❑ 1 **IPV:** ❑ 1 ❑ 2 ❑ 3 ❑ 4

MCV4: ❑ 1 ❑ 2 **MMR:** ❑ 1 ❑ 2 **Td:** ❑ 1 ❑ 2❑ 3 ❑ B **Tdap:** ❑ 1 ❑ 2 ❑ 3 ❑ B **Men B:** ❑ 1❑ 2

Varicella: ❑ 1❑ 2 **COVID:** ❑ 1 **MMRV:** ❑ 1 ❑ 2 **DTaP:** ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 **Men ABCWY:** ❑ 1 ❑ 2

Acknowledgement *by signing below, you acknowledge the following:*

I have been given a copy and have read or have had explained to me the information contained in the appropriate vaccine information materials (fact sheets) about the disease(s) and vaccine(s) indicated above.

I have had a chance to ask questions that were answered to my satisfaction.

I believe I understand the benefits and risks of the indicated vaccine(s) and ask that the vaccine(s) checked above be given to me or to the person named below.

Furthermore, if the person named below is a minor child, I attest that I am the child's parent, authorized representative, or legal guardian and may provide effective consent for this immunization.

*Return Signed Form to School Based Clinic

_____
Student Name and Student ID# *(please print)*

_____ _____
Student Signature *if over 18 years of age* Date

_____ _____
Parent/Guardian name *please print* Phone Number

_____ _____
Parent/Guardian Signature Date

To get information for vaccines needed please obtain Vaccine Information Statement (VIS):

https://www.cdc.gov/vaccines/hcp/vis/current-vis.html

Immunization Contraindication Review

Febrile illness/Active infection/Fever > 101 ❑ Yes ❑ No **Serious reaction to vaccine in the past?** ❑ Yes ❑ No

IPV

Patient has had a pregnancy? ❑ Yes ❑ No **Allergy to neomycin, streptomycin, polymyxin B?** ❑ Yes ❑ No

MMR & Varicella

Allergy to gelatin? ❑ Yes ❑ No **Allergy to neomycin?** ❑ Yes ❑ No

Pregnancy? ❑ Yes ❑ No *You must not now be pregnant and should not get pregnant for 4 weeks. If you have intercourse, use effective birth control methods.*

Immunosuppression of patient? ❑ Yes ❑ No

Hep B

Allergy to baker's yeast? ❑ Yes ❑ No

Influenza

This is my first flu shot ❑ Yes ❑ No

Allergy to eggs, chicken products, Thimerosol (preservative), gentamicin, arginine, or any component of the flu vaccine? ❑ Yes ❑ No

I have a fever today. ❑ Yes ❑ No **History of Guilláin-Barre Syndrome?** ❑ Yes ❑ No

I take a prescription blood thinner: ❑ Yes ❑ No Name:_____

TDaP, DTaP

Allergy to Latex? ❑ Yes ❑ No **History of epilepsy/seizure or nervous system problem?** ❑ Yes ❑ No

History of Guillián-Barre Syndrome? ❑ Yes ❑ No