Parental Consent for Vaccine Administration at School

This is a pilot program with the Nevada State Health Division. The Health Division is collecting data on insurance status. Please provide the basic information requested for the person receiving the vaccine.
An administration fee of $15 per vaccine is requested when the consent form is returned to the school; however the vaccine will be provided to all students regardless of ability to pay. **Please pay what you feel you can afford**. Checks should be made payable to Elko County School District.

Student's Name _____ Birth Date _____/_____/_____ Age Today _____
Month Day Year

Gender ☐ M or ☐ F Mother's Name: _____

Mailing Address: _____ City / State / Zip _____

Physical Address: _____ City / State / Zip _____

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Race: ☐ Caucasian ☐ Black ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

Status of insurance coverage:

☐ Uninsured ☐ Medicaid ☐ Nevada Check Up
☐ Commercial Insurance Company – (provide name of company and type of plan-HMO/PPO/Other – if you know)

_____

☐ Underinsured (insured but insurance does not cover cost of vaccines~provide name of insurance provider)

_____

☐ Don't Know

Please circle answers to questions about the PERSON RECEIVING IMMUNIZATIONS:

Yes	No	Does he/she have allergies to gelatin, medications, a vaccine component, or latex? (please specify)
Yes	No	Has he/she had a serious reaction to vaccine in the past?
Yes	No	Has he/she had a seizure; has he/she had brain or other nervous system problems?
Yes	No	Does he/she have cancer, leukemia, AIDS, or any other immune system problems?
Yes	No	In the past 3 months, has he/she taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?
Yes	No	In the past year, has he/she received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?
Yes	No	Is she pregnant or is there a chance she could become pregnant during the next month?
Yes	No	Has he/she received vaccinations in the past 4 weeks?

My signature below verifies the following:

- I have received and understand the vaccine information statement(s) for the following vaccines:
  ☐ Dtap ☐ Tdap ☐ Polio ☐ Hepatitis A ☐ Hepatitis B ☐ MMR ☐ Varicella ☐ Meningococcal ☐ HPV
- I authorize the Elko County School District nurses to administer the following vaccines to my child at school.
  ☐ Dtap ☐ Tdap ☐ Polio ☐ Hepatitis A ☐ Hepatitis B ☐ MMR ☐ Varicella ☐ Meningococcal ☐ HPV
- I authorize Elko County School District or the Nevada State Health Division to enter this information into the Nevada Immunization Registry.

Parent/Guardian Signature _____ Date _____/_____/_____

☐ Please check the box if you would like a copy of Nevada's privacy policy to be sent home with your child after immunizations.

Please do not write below this Line

Vaccine	Date Dose Given	Lot Number/Expiration Date	Route/Site	Signature & Title of Vaccine Administrator