Anchorage School District

IMMUNIZATION CONSENT FORM

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
STREET ADDRESS			GENDER ☐ Male ☐ Female
CITY	STATE	ZIPCODE	TELEPHONE
RACE ☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black or African American ☐ Multiracial ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown ☐ White			ETHNICITY ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
MOTHER'S MAIDEN NAME (LAST, FIRST)	NAME OF SCHOOL		GRADE
NAME OF PARENT / GUARDIAN			RELATIONSHIP TO CHILD

VACCINE ELIGIBILITY

One box from this section must be selected to be eligible to receive a free vaccine.

- ☐ **Medicaid or Denali Kid Care** (VFC Medicaid Eligible)
- ☐ **No medical insurance** (VFC Uninsured)
- ☐ **Native American or Alaska Native**
- ☐ **Insurance or Insurance does not cover vaccines** (State Vaccine AVAP)

Please answer the questions below. Your answers will be used to determine if it is safe to administer immunizations today. If you answer "YES" to any of these questions, an ASD nurse will review your health information. In some instances, a nurse cannot administer a vaccine unless you have a medical provider's note stating it is safe for you to be immunized.

	YES	NO
Are you sick today?		
Do you have allergies to medications (e.g. antibiotics), food, a vaccine component, or latex?		
Have you had a serious reaction to a vaccine in the past?		
Have you ever had Guillain–Barre Syndrome (a type of temporary severe muscle weakness)?		
Do you have any long-term health problems including lung, heart, kidney, metabolic (e.g., diabetes), and/or a blood disorder?		
Have you had a seizure, brain or other nervous system problem?		
Does you or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
In the past 3 months, have you 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?		
In the past year have you received a blood transfusion, blood products (e.g. plasma), or been given immune (gamma) globulin?		
Are you currently taking any antiviral medications, for example those used to suppress the herpes virus?		
Are you pregnant or planning to become pregnant in the next month?		
Have you received vaccinations in the past 4 weeks?		

This consent is valid for the following vaccines: _____

The most current Vaccine Information Sheet (VIS) has been made available for me to read. I understand their contents and hereby consent to receive (or for my child to receive) the indicated vaccine(s). **YES**, I give authorization for the nurse to review and enter the administration into VacTrAK, a vaccination record system managed by the State of Alaska, Department of Health and Social Services, Section of Epidemiology.

PRINTED NAME (Parent/guardian if person is under 18 years old)	
SIGNATURE	DATE SIGNED

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VACCINATION RECORD – FOR NURSE USE ONLY

VACCINE TYPE	DATE VACCINE ADMINISTERED	ROUTE AND ANATOMICAL SITE (PLEASE CIRCLE)	MANUFACTURER, LOT NUMBER, EXPIRATION DATE, AND VIS DATE	VACCINATOR'S PRINTED NAME AND SIGNATURE
TDaP (7 years and older)		IM – Right deltoid IM – Left deltoid IM – Right anterolateral thigh IM – Left anterolateral thigh	Manufacturer: Lot Number: Expiration Date: **VIS Date:**	
DTaP (Less than 7 years old)		IM – Right deltoid IM – Left deltoid IM – Right anterolateral thigh IM – Left anterolateral thigh	Manufacturer: Lot Number: Expiration Date: **VIS Date:**	
DTaP/ Hep B/ Polio Combo (Less than 7 years old)		IM – Right deltoid IM – Left deltoid IM – Right anterolateral thigh IM – Left anterolateral thigh	Manufacturer: Lot Number: Expiration Date: **VIS Date:**	
Hep A		IM – Right deltoid IM – Left deltoid IM – Right anterolateral thigh IM – Left anterolateral thigh	Manufacturer: Lot Number: Expiration Date: **VIS Date:**	
Hep B		IM – Right deltoid IM – Left deltoid IM – Right anterolateral thigh IM – Left anterolateral thigh	Manufacturer: Lot Number: Expiration Date: **VIS Date:**	
HPV (Gardasil 9)		IM – Right deltoid IM – Left deltoid IM – Right anterolateral thigh IM – Left anterolateral thigh	Manufacturer: Lot Number: Expiration Date: **VIS Date:**	
MCV (Meningococcal ACWY)		IM – Right deltoid IM – Left deltoid IM – Right anterolateral thigh IM – Left anterolateral thigh	Manufacturer: Lot Number: Expiration Date: **VIS Date:**	
Polio (IPOL/IPV)		IM – Right deltoid IM – Left deltoid SC – Right upper arm SC – Left upper arm	Manufacturer: Lot Number: Expiration Date: **VIS Date:**	
MMR (Measles, mumps, rubella)		SC – Right upper arm SC – Left upper arm	Manufacturer: Lot Number: Expiration Date: **VIS Date:**	
Varicella (Chickenpox)		SC – Right upper arm SC – Left upper arm	Manufacturer: Lot Number: Expiration Date: **VIS Date:**	