Pathways Wellness Program

Wellness4Schools

Student Consent Form

School Site: _____ Date of Clinic: _____

Student Name: _____ Date of Birth: _____

Guardian Name: _____ Relationship to Student: _____

CONSENT: I consent to the following vaccine(s) to be given to my student. I have been given the Vaccine Information Statements from the Centers for Disease Control, and understand the possible side effects that should be taken into consideration prior to administration of the vaccine. I give permission to Pathways Wellness Program and staff to vaccinate my student and to report any data collected on this form to the required state and/or federal agencies as required. Privacy Practices: I acknowledge that Notice of Privacy Practices were made available to me.

Please check all vaccines that you are consenting your student to receive:

Flu:_____ Hepatitis B:_____ HPV:_____ MMR II:_____

DTaP:_____ TDAP:_____ Varicella:_____ Meningococcal ACWY:_____

Polio:_____ Meningococcal B:_____ COVID-19:_____

Fever or feeling ill today?	☐ No	☐ Yes – Defer until feeling better
History of severe allergic reaction, including anaphylaxis to any component of this vaccine?	☐ No	☐ Yes – STOP do not vaccinate
History of severe allergic reaction, including anaphylaxis to any vaccine, other than this vaccine?	☐ No	☐ Yes – Defer; consult with PCP
History of severe allergic reaction, including anaphylaxis to an injectable therapy?	☐ No	☐ Yes – Defer; consult with PCP
History of severe allergic reaction due to any cause?	☐ No	☐ Yes – Require 30 min observation
Do you have a weakened immune system, caused by something like HIV infection or cancer or do you take immunosuppressant drugs or therapies?	☐ No	☐ Yes – Defer; consult with PCP
Are you pregnant or breastfeeding?	☐ No	☐ Yes – Defer; consult with PCP
Has your child ever had Guillain-Barŕe syndrome?	☐ No	☐ Yes – Defer; consult with PCP
For COVID-19 Immunization		
Have you ever received a dose of COVID-19 Vaccine?	☐ No	☐ Yes – ensure vaccine type & appropriate interval
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ No	☐ Yes – STOP do not vaccinate for 90 days since last treatment date
Have you received another vaccine in the last 14 days?	☐ No	☐ Yes – STOP do not vaccinate for 14 days

Signature of Legal Guardian: _____ Date: _____

Billing Form: to be completed by the Nurse

1. Vaccines Administered

Flulaval _____

Fluad - HD Flu _____

Shingrix- Shingles _____

Prevnar 13- PCV13 _____

Pneumovax 23 _____

Boostrix- TDAP/Tetanus Diphtheria Pertussis _____

Gardasil 9 - HPV _____

Menveo - Meningitis ACWY 10mccg/0.5 _____

Moderna – Covid 19 _____

Pfizer – Covid 19 _____

Other:_____ _____

Other: _____ _____

2. Vaccine Administration Record

Vaccine	Dose Number	Date Administered	Site and Route	Manufacturer / Lot No.	Date VIS given to patient
Influenza			RD LD IM SC		
Shingrix - Shingles	Dose 1 Dose 2		RD LD IM SC		
Prevnar 13 Pneumonia conjugate PCV13			RD LD IM SC		
Pneumovax 23 Pneumonia polysaccharide PPSV23			RD LD IM SC		
Boostrix Tdap			RD LD IM SC		
Menveo Meningitis ACWY			RD LD IM SC		
Gardasil 9 HPV			RD LD IM SC		
Pfizer Covid 19	Dose 1 Dose 2		RD LD IM SC		
Moderna Covid 19	Dose 1 Dose 2		RD LD IM SC		
Other	Dose 1 Dose 2 Dose 3		RD LD IM SC		
Other			RD LD IM SC		

Vaccine(s) administered by: _____Title: _____

(Nurse Signature)