

Minor Consent Form

Please bring to clinic and the nurse will attach to Patient/Student Record 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 the minor listed above. 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Defer until feeling better
History of severe allergic reaction, including anaphylaxis to any component of this vaccine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – STOP do not vaccinate
History of severe allergic reaction, including anaphylaxis to any vaccine, other than this vaccine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Defer; consult with PCP
History of severe allergic reaction, including anaphylaxis to an injectable therapy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Defer; consult with PCP
History of severe allergic reaction due to any cause?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Defer; consult with PCP
Are you pregnant or breastfeeding?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Defer; consult with PCP
Has your child ever had Guillain-Barfe syndrome?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Defer; consult with PCP
For COVID-19 Immunization		
Have you ever received a dose of COVID-19 Vaccine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – ensure vaccine type & appropriate interval
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – STOP do not vaccinate for 90 days since last treatment date
Have you received another vaccine in the last 14 days?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – STOP do not vaccinate for 14 days

Signature of Legal Guardian: _____

Date: _____