Pathways Wellness Program

Walk-In Minor Consents - Must be signed by Parent

Location: _____ Date: _____

Name: _____ Date of Birth: _____ Age: _____

Gender: (M)____ (F)_____ Phone: _____ Last 4 Digits Social Security #: _____

Home Address: _____City: _____ State: ____ Zip: _____

Email: _____

Full name of Insurance Plan: _____

ID #_____ Group #:_____

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? DATE:	☐ 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

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.

Signature of Guardian: _____ Date: _____

Screening questions reviewed by: _____ Title: _____

Billing Form: to be completed by the Nurse

1. Vaccines Administered

Flulaval	_____	Moderna	_____
Boostrix- TDAP/Tetanus Diphtheria Pertussis	_____	Pfizer	_____
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		
Boostrix Tdap			RD LD IM SC		
Menveo Meningitis ACWY			RD LD IM SC		
Pfizer (12 & older) Covid 19	Dose 1 Dose 2 Booster		RD LD IM SC		
Pfizer (5-11) Covid 19	Dose 1 Dose 2		RD LD IM SC		
Pfizer (0-<5)	Dose 1 Dose 2 Dose 3		RVL LVL RD LD IM SC		
Moderna (6 month through 5yr)	Dose 1 Dose 2		RVL LVL RD LD IM SC		
Moderna (6 through 11 yr)	Dose 1 Dose 2 Dose 3		RVL LVL RD LD IM SC		
Moderna 12 through 17 yr)	Dose 1 Dose 2 Dose 3		RVL LVL RD LD IM SC		
Other:			RD LD IM SC		
Other:			RD LD IM SC		

Vaccine(s) administered by: _____Title: _____
(Nurse Signature)