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**Minor Walk In Consent Form**

**Vaccine(s) Requested:**

**Clinic Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Guardian Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Plan Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| 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 |
| Have you ever had Guillain-Barѓe syndrome? | No | Yes – Defer; consult with PCP |
| Have you had any LIVE vaccines in the past 30 days? | No | Y- Yes- it is recommended to space live vaccines by > or = 4 weeks for full efficacy |

**CONSENT**: I consent to the above vaccine(s) to be given to my student. I have been given the [Vaccine Information Statements](https://www.cdc.gov/vaccines/hcp/current-vis/?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/vis/current-vis.html) 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.

Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Screening questions reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Print Immunization Clinician Name)**

**Billing & Vaccine Administration Record: to be completed by the Immunization Clinician**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vaccine** | **Date Administered** | **Dose #** | **Site and Route** | **Manufacturer / Lot No.** | **VIS Date** |
| **INFLUENZA**  (90656) |  |  | RD LD  IM SC |  | 01/31/2025 |
| **Pfizer COVID-19 (12 yrs +)**  (91320) |  |  | RD LD  IM SC |  | 01/31/2025 |
| **Varicella: Chicken Pox**  (90716) |  |  | RD LD  IM SC |  | 01/31/2025 |
| **Priorix: MMR**  (90707) |  |  | RD LD  IM SC |  | 01/31/2025 |
| **Boostrix: TDAP**  (90715) |  |  | RD LD  IM SC |  | 01/31/2025 |
| **Heplisav or Energix: Hepatitis B**  (90744) |  |  | RD LD  IM SC |  | 01/31/2025 |
| **Menveo: MCV / Meningococcal ACWY**  (90734) |  |  | RD LD  IM SC |  | 01/31/2025 |
| **Bexsero: Meningococcal B**  (90620) |  |  | RD LD  IM SC |  | 01/31/2025 |
| **Ipol: Polio**  (90713) |  |  | RD LD  IM SC |  | 01/31/2025 |
| **Other** |  |  | RD LD  IM SC |  | 01/31/2025 |
| **Other** |  |  | RD LD  IM SC |  | 01/31/2025 |

Vaccine(s) administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Immunization Clinician Signature)