

**Minor Immunization Request & Consent Form***Please include a copy of the Patient’s Insurance Card*

**Clinic Location: Date of Clinic:**

**Student Name: Student Date of Birth:**

**Guardian Name: Relationship to Student:**

**Guardian Phone: Guardian Address:**

**Guardian Email:**

**Insurance Plan Name: Insurance ID:**

**REQUEST:** Choose the vaccines below that you request be given to your child. Pathways will verify eligibility and contact you at the phone number on this form of any copay or contraindication.

|  |  |  |  |
| --- | --- | --- | --- |
| **Flu** |  | **Heplisav or Energix: Hepatitis B** |  |
| **Pfizer COVID-19 (12 yrs +)** |  | **Priorix: MMR** |  |
| **Menveo: MCV / Meningococcal ACWY** |  | **Varicella: Chicken Pox** |  |
| **Boostrix: TDAP** |  | **Bexsero: Meningococcal B** |  |
| **Pneumonia: Prevnar 20** |  | **Gardasil 9: HPV** |  |

 **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| Patient Questions: |  |  |
| 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 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 |

 **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 LDIM SC |  | 01/31/2025 |
| **Pfizer COVID-19 (12 yrs +)**(91320)  |  |  | RD LDIM SC |  | 01/31/2025 |
| **Varicella: Chicken Pox**(90716) |  |  | RD LDIM SC |  | 01/31/2025 |
| **Priorix: MMR**(90707) |  |  | RD LDIM SC |  | 01/31/2025 |
| **Boostrix: TDAP**(90715) |  |  | RD LDIM SC |  | 01/31/2025 |
| **Heplisav or Energix: Hepatitis B**(90744) |  |  | RD LDIM SC |  | 01/31/2025 |
| **Menveo: MCV / Meningococcal ACWY**(90734) |  |  | RD LDIM SC |  | 01/31/2025 |
| **Bexsero: Meningococcal B**(90620) |  |  | RD LDIM SC |  | 01/31/2025 |
| **Ipol: Polio**(90713) |  |  | RD LDIM SC |  | 01/31/2025 |
| **Other** |  |  | RD LDIM SC |  | 01/31/2025 |
| **Other** |  |  | RD LDIM SC |  | 01/31/2025 |

**Vaccine(s) administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 (Immunization Clinician Signature)