Date: _____
Time In: _____
Time Out: _____

FLORIDA DEPARTMENT OF HEALTH IN BROWARD COUNTY
IMMUNIZATION SCREENING AND CONSENT FORM

Your child may need <u>one or more</u> vaccines required for school attendance. For your child to receive vaccines **<u>you must answer all questions and sign this consent form.</u>** A nurse from Florida Department of Health in Broward County will provide the needed immunizations to eligible children, free of charge through its participation in the State of Florida's Vaccines for Children program.

SECTION 1: INFORMATION ABOUT CHILD (PLEASE PRINT)

Child's Name:

Last: First: M.I.:

Child's Date of Birth: Child's Age: Male ☐ Female ☐
Month……Day……Year……

Parent/Legal Guardian's Name:
Last: First: M.I.:

Parent/Legal Guardian's Daytime Phone Number(s):

Home Address: Apt.#

City: State: Zip:

Race: (Select all that apply) American Indian or Alaska Native ___ Asian ___ Black or African American ___
Native Hawaiian or Other Pacific Islander ___ White ___

Hispanic/Latino: Yes ____ No ____ **Preferred Language** _____

SECTION 2: SCREENING FOR VACCINE ELIGIBILITY

The following questions will help us determine which vaccines the child may be given. If you answer "yes" to any question, it does not necessarily mean the child should not be vaccinated.

Please check YES or No for each question.	**Yes**	**No**
1. Is the child sick today?		
2. Does the child have allergies to **medications, food, a vaccine component, or latex**? Please explain:		
3. Has the child had a **serious reaction** to a vaccine in the past?		
4. Has the child had a health problem with **lung, heart, kidney or metabolic disease** (e.g. diabetes), **asthma** or a **blood disorder**?		
5. Has the **child,** a **sibling**, or a **parent** had a **seizure**; has the child had **brain** or other **nervous system** problems?		
6. Does the **child** have **cancer, leukemia, HIV/AIDS** or any other **immune system** problems?		
7. In the past **three months** has the child taken **medications** that affect the immune system such as **prednisone, other steroids**, or **anticancer drugs**; drugs for the treatment of **rheumatoid arthritis**, **Crohn's disease**, or **psoriasis;** or had **radiation treatment**?		
8. In the past year, has the child received a **transfusion** of **blood** or **blood products** or been given **immune (gamma) globulin** or an **antiviral drug**?		
9. Is the child/teen **pregnant** or is there a **chance** she could become pregnant during the next month?		
10. Has your child **been vaccinated within the last 30 days**? If YES Vaccine type and date:		

SECTION 3: CONSENT FOR CHILD'S VACCINATION.

I have received, read and understood the Vaccine Information Statements (VIS) related to the recommended vaccines. I have had the opportunity to ask questions and discuss my concerns with a healthcare professional. **I give permission** for a nurse from the Florida Department of Health in Broward County to give one or more vaccines required for school attendance and/or recommended by the United States Centers for Disease Control and Prevention and the American Academy of Pediatrics and the American Academy of Family Physicians to my child. Copies of the VIS for each vaccine is attached. I have also received a Notice of Privacy Practices related to the use of medical information.

The record of your child's vaccination will be entered into Florida Shots, the Department of Health Bureau of Immunization system for storing shot records. This system is secure and can only be used by approved doctors, nurses, and schools. This ensures that the vaccine history is accessible whenever your child is seen by a doctor or if s/he changes schools. If you do not want your child's data tracked in Florida Shots please contact 1-877-888-7468.

I, _____ **(PLEASE PRINT NAME of *consenting adult*)** have the following relationship with the **child named above** (*please check relationship to child*):

□ Mother □ Stepparent □ Adult Brother* □ Adult Aunt*
□ Father □ Grandparent □ Adult Sister* □ Adult Uncle*
□ Legal Guardian □ Legal Custodian *Older than 18 years of age

I have the legal authority, based on the relationship to the child as indicated above, pursuant to s.743.0645, F.S., to consent to vaccinations for the child named above.

Signature: _____ **Date: Month**_____ **Day**_____ **Year**_____

1. Does the child have Medicaid? □ YES □ NO
2. If no Medicaid, does the child have other health insurance? □ YES □ NO
   If yes, does the child's health insurance cover all vaccines? □ YES □ NO
   Have you gone over the amount your child's health insurance pays for vaccines? □ YES □ NO

DOH Administrative Use Only

Screener Name: Title/Sig _____ **Date:** _____

Florida Shots Look Up Attached: Yes ☐ **Not Found** ☐

Vaccinator- Fill out form

Vaccine	Site	Route	Mfg.	Lot #	Exp Date	Notes
DTap *(Diphtheria, Tetanus, Pertussis)*		IM				
Hep B *(Hepatitis B)*		IM				
HIB (*Haemophilus Influenzae Type B)*		IM				
HPV9 (*Human Papillomavirus)*		IM				
IPV *(Inactivated Polio)*		IM				
MenACWY*(MCV4)*Meningococcal Conjugate)		IM				
MMR *(Measles, Mumps, and Rubella)*		SC				
PCV13 (*Pneumococcal Polysaccharide)*		IM				
TD TENIVAC *(Tetanus Diphtheria)*		IM				
Tdap (*Tetanus, Diphtheria ,Pertussis)*		IM				
VZV Varicella *(Chickenpox)*		SC				

☐ **Part A (K-12 Requirements, Excluding 7th Grade**
☐ **Part A (7th Grade Requirements Only)**
☐ **Part B (Temp Medical Exemption Expiration**
☐ **Part C (Permanent Medical Exemption)**
☐ **680 Only Certification**

Vaccinator Name: Title & Sig: _____ **Date:** _____