NEW MEXICO DEPARTMENT OF HEALTH

SCHOOL IMMUNIZATION CONSENT FORM

Update: August 2019

For school office use: Place sticker/stamp with school address here

Please fill in form completely – required fields are marked with an asterisk (*)

***Student's Legal Last Name**:	***First Name:**	**MI:**
***Date of Birth**:_____ **Age:**_____ Month/ Day / Year	***Mother's Maiden (birth) Name:**	***Mother's First Name:**
***Mailing Address**:	***City:**	***State**: NM **Zip:**
***Daytime Phone**:	***Student ID#:** _____ ***Grade:** _____	***School:**_____ ***Teacher:** _____
***Sex:** ☐ Male ☐ Female	**Race:** ☐African American ☐Asian ☐White ☐American Indian/Alaskan Native ☐Other	**Ethnicity**: ☐ Hispanic ☐ Non-Hispanic

☐ **Remind Me:** I consent to vaccine reminders by email, text, phone call, or mail for the person receiving the vaccine.

INSURANCE INFORMATION – Please mark appropriate category – REQUIRED*

☐ **Centennial Care/Medicaid**:

Select your Centennial Care Plan: ☐Blue Cross Blue Shield ☐Presbyterian ☐Western Sky Community Care ☐Other_____

Centennial Care (Medicaid) Card ID #: _____ Health Insurance Member ID #:_____ Group #:_____

☐ **My child has private or commercial health insurance.**

☐ **My child does not have health insurance.**

SELECT THE VACCINE(S) YOU WOULD LIKE YOUR CHILD TO RECEIVE AT SCHOOL:

☐ HPV (recommended 2 or 3 doses based on age)

☐ Meningococcal (required at age 11-12 for 7th grade school entry; booster recommended at age 16-17; MenACWY strongly recommended ages 13-18)

☐ Tdap (required for 7th grade school entry) ☐ Other vaccine (if offered): _____

MEDICAL SCREENING QUESTIONS FOR CHILDREN AND TEENS – REQUIRED

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "**yes**" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.	**Yes**	**No**	**I don't know**
1. Is the child sick today?			
2. Does the child have allergies to medications, food, a vaccine component, or latex?			
3. Has the child has 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? Is he/she on long-term aspirin therapy?			
5. Has the child, sibling, or parent had a seizure; has the child had a brain or other nervous system problems?			
6. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?			
7. In the past 3 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 treatments?			
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 there is a chance she could become pregnant during the next month?			
10. Has the child received vaccinations in the past 4 weeks?			

CONSENT FOR VACCINATION*

I have read or have had explained to me the information in the Vaccine Information Statement (VIS) for the disease(s) and vaccine that I have selected for my child on the attached letter. I understand the benefits and risks of each vaccine and consent that the vaccines I have selected to be given to the above named child. I understand that some vaccines are given in a series over a period of time that by signing this form I consent to all the vaccines including those needed to complete a series. **I will contact the school nurse to withdraw this consent if my child is immunized before the date of the school clinic or for any reason.** Unless I sign a statement signifying otherwise, I allow immunization information to be entered into the New Mexico Statewide Immunization Information System (NMSIIS) and be releases to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. The revised DOH Privacy Policy is at https://nmhealth.org/help/privacyamd will be provided to all student when they receive an immunization.

***Signature (Client/Guardian):**_____ ***Date:**_____

***Print Name (Client/Guardian):**_____

***Name of Child (if a minor):**_____ ***Date of Birth:**_____

DIRECT NMSIIS ENTRY OF VACCINES ADMINSTERED IS REQUIRED within 10 days of administration.

This form was designed for NM DOH public health offices and program use only. NM DOH is not responsible for data entry or vaccine administration from outside health entities and expressly disclaims liability for any associated errors as a result from utilization of this form.

Student's Name:_____ **Date of Birth:**____/____/_____ **Vaccine Admin. Date:**____/____/_____

FOR CLINIC USE ONLY – All data elements below are required for each vaccine administered*

Vaccine	Lot #	Site/ Route (codes below)	Vaccine Expiration Date	Funding (VFC/State)	VIS Edition Date
DTAP ☐ Daptacel (SP) ☐ Infanrix (GSK)			/ /		/ /
DTaP/IPV/Hib ☐ Pentacel (SP)			/ /		/ /
DTaP/HepB/IPV ☐ Pediarix (GSK)			/ /		/ /
DTaP/IPV ☐ Kinrix (GSK) ☐ Quadracel (SP)			/ /		/ /
HEP A ☐ Havrix (GSK) ☐ Vaqta (Merck)			/ /		/ /
HEP B ☐ Engerix B (GSK) ☐ Recombivax (Merck)			/ /		/ /
Hib ☐ ActHIB (SP) ☐ PedvaxHIB (Merck)			/ /		/ /
HPV ☐ Gardasil 9 (Merck)			/ /		/ /
Influenza ☐ Flucelvax (Sequirs) ☐ Fluzone (.25ml/.5ml) (SP) ☐ Flulaval (GSK) ☐ Other			/ /		/ /
MCV4 ☐ Menactra (SP) ☐ Menveo (GSK)			/ /		/ /
Men B ☐ Trumenba (Pfizer) ☐ Bexsero (GSK)			/ /		/ /
MMR ☐ MMR II (Merck)			/ /		/ /
MMRV ☐ ProQuad (Merck)			/ /		/ /
PCV13 ☐ Prevnar13 (Pfizer)			/ /		/ /
Polio (IPV) ☐ IPOL (SP)			/ /		/ /
PPSV23 ☐ Pneumovax 23 (Merck)			/ /		/ /
Rotavirus ☐ Rotarix (GSK) ☐ RotaTeq (Merck)			/ /		/ /
Td /Tdap ☐ Tenivac (SP) ☐ Boostrix (GSK)			/ /		/ /
Varicella ☐ Varivax (Merck)			/ /		/ /
Other:			/ /		/ /
Other:			/ /		/ /

RA/IM (Right Arm/Intramuscular) **LA/IM** (Left Arm/Intramuscular) **RT/IM** (Right Thigh/Intramuscular) **LT/IM** (Left Thigh/Intramuscular) **IN** (Intranasal)
RA/SC (Right Arm/Subcutaneous) **LA/SC** (Left Arm/Subcutaneous) **RT/SC** (Right Thigh/Subcutaneous) **LT/SC** (Left Thigh/Subcutaneous) **PO** (By Mouth)

***VACCINATOR:** _____
(Print Name & Title) (Signature) (Date of Clinic) (Date VIS given) (VFC PIN #)

*NMSIIS Entry Date:_____ TransactRx Entry Date (if applicable)_____