Off-Site Consent for Immunization and Questionnaire

Insurance type: _____
Policy number: _____
Member ID: _____
Etc. _____

Dear Parent or Guardian,

Did you know that immunizations are one of the most effective ways to protect against vaccine preventable diseases? Sanford Health is hosting an upcoming event that will include an opportunity to vaccinate children who are due or overdue for one or more immunizations.

At 11-12 years of age, additional immunizations are recommended. Your child may be due for an immunization(s). To have your child immunized with the recommended vaccines, follow the steps below:

1. Check the boxes beside the immunization(s) you would like your child to receive.
2. Complete the vaccine-screening checklist.
3. Sign the consent section on the form.
4. Return this form to the event location

Recommended Immunizations for ages 11-18 include:

☐ **Human Papillomavirus**
Protects against certain types of cancer.

☐ **Tetanus, Diphtheria, and Pertussis**
Protects against Tetanus, Diphtheria, and Whooping Cough.

☐ **Meningitis ACWY**
Protects against bacteria that can infect blood, the brain, or spinal cord.

☐ **Meningitis B**
Protects against bacteria that can infect blood, the brain, or spinal cord.

☐ **Influenza (Flu)**
Protects against an infection in the respiratory tract (mouth, nose, and lungs). This vaccine is available September through May each year.

☐ **Coronavirus (COVID-19)**
Protects against a viral infection in the respiratory tract (mouth, nose, and lungs).

Off-Site Consent for Immunization and Questionnaire

Vaccine Screening Checklist

Is your child sick today? ☐ Yes ☐ No ☐ Unsure

Does your child have allergies to medications, food, part of a vaccine, or latex?
☐ Yes ☐ No ☐ Unsure
If yes, please list the allergies _____

Has your child ever had a serious reaction after receiving a vaccination? ☐ Yes ☐ No ☐ Unsure
If yes, what vaccine _____

Does your child have a long-term health problem with lung, heart, kidney or disease (such as diabetes), asthma, a blood disorder, no spleen, immune deficiency, a cochlear implant, or a spinal fluid leak? ☐ Yes ☐ No ☐ Unsure

Is your child or teen age 6 months through 17 years and receiving aspirin or salicylate-containing medicine? ☐ Yes ☐ No ☐ Unsure

Has your child, a brother/sister, or a parent had a seizure? ☐ Yes ☐ No ☐ Unsure
If yes, who? _____

Has your child had brain or nervous system problems? ☐ Yes ☐ No ☐ Unsure

Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problems?
☐ Yes ☐ No ☐ Unsure

In the past 3 months, has your 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? ☐ Yes ☐ No ☐ Unsure
If yes, please list the name of medication and for what illness.

_____

_____

In the past year, has your child received a transfusion of blood or blood products, **or** been given immune (gamma) globulin or an antiviral drug? ☐ Yes ☐ No ☐ Unsure

Off-Site Consent for Immunization and Questionnaire

In the past year, has your child been given antiviral medication? ☐ Yes ☐ No ☐ Unsure

For females: Is your child pregnant or is there a chance she could become pregnant during the next month? ☐ Yes ☐ No ☐ Unsure

Has your child received vaccinations in the past 4 weeks? ☐ Yes ☐ No ☐ Unsure
If yes, please list which vaccines and when they were given.

_____

_____

Has your child ever had Guillain-Barré syndrome? ☐ Yes ☐ No ☐ Unsure

Is your child anxious about getting a shot today? ☐ Yes ☐ No ☐ Unsure

Has your child every felt dizzy or faint before, during or after a shot? ☐ Yes ☐ No ☐ Unsure

Consent to share vaccine info with Minnesota Immunization Information Connection (MN Clinics only)
☐ Yes ☐ No

Consent

I have been provided and reviewed all of the risks and benefits in the Vaccine Information Statement(s). I understand these risks and benefits and have had an opportunity to have all of my questions answered.

I give consent for my child to receive the immunizations checked above, if due or past due. The immunizations will be given by staff from Sanford Health. The cost will be billed to my insurance.

_____
Printed name of child

_____
Printed name of parent or guardian

_____ _____ _____
Signature of parent or guardian Date Time