Exam Consent Form

Place patient identification sticker here

Date: _____

Legal Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____ Patient Address: _____

I am the parent/legal guardian of the above-named patient, and I consent to a sports physical examination by a Sanford Health provider of the patient.

Additionally, I have reviewed the attached Vaccine Information Sheet(s), and consent to one or more of the following vaccinations if the patient is due for vaccine(s) in accordance with the Centers for Disease Control and Prevention immunization schedule.

- ☐ Tetanus, diphtheria, & acellular pertussis (Tdap)
- ☐ Human papillomavirus (HPV)
- ☐ Meningococcal B
- ☐ Meningococcal ACWY

Please answer the following to consent to vaccine(s)

1. Is the child sick today? Yes No
2. Does the child have allergies to medicine, food, a vaccine component, or latex? Yes No
3. Has the child had a serious reaction to a vaccine in the past? Yes No
4. Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication? Yes No
5. For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? Yes No
6. For babies: Have you ever been told the child had intussusception? Yes No
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem? Yes No
8. Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19? Yes No
9. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS? Yes No
10. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Yes No
11. Does the child's parent or sibling have an immune system problem? Yes No
12. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug? Yes No

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13. Is the child/teen pregnant? Yes No
14. Has the child received vaccinations in the past 4 weeks? Yes No
15. Has the child ever felt dizzy or faint before, during, or after a shot? Yes No
16. Is the child anxious about getting a shot today? Yes No

If yes to any of the above questions, please explain: _____

_____

I have reviewed, or had the opportunity to review, all information necessary for me to make an informed decision about giving consent for the treatment above, including considering the risks, goals, benefits, and alternatives of such treatment(s).

_____ _____ _____

Signature of Parent/Legal Guardian Date Time

_____

Printed Name of Parent/Legal Guardian