Health, Housing and Community Services
Berkeley High School Health Center

IMMUNIZATION SCREENING/CONSENT FORM

Student's Name: _____ Date of Birth: _____/_____/_____

Address:_____

Phone: _(_____)_____

I REQUEST THE FOLLOWING IMMUNIZATIONS FOR MY CHILD/MYSELF:

- ☐ Hepatitis A [2 dose series]
- ☐ Hepatitis B [3 dose series]
- ☐ Human Papillomavirus (HPV) [3 dose series]
- ☐ Measles/Mumps/Rubella (MMR) [2 dose series]
- ☐ Meningococcal (MCV4) [2 dose series]
- ☐ Polio [4 dose series]
- ☐ Tetanus/Diptheria/Pertussis (TDAP) [1 booster]
- ☐ Varicella (Chickenpox) [2 dose series]

VFC QUALIFICATION:

Please choose the correct response pertaining to your child. Proof is not required.

- ☐ No health insurance
- ☐ Medi-Cal/CHDP eligible
- ☐ Is American Indian or Alaska Native
- ☐ Private Insurance

CONSENT

I have read or have had explained to me the information provided about the vaccine(s) requested above. I have had an opportunity to ask questions which were answered to my satisfaction [Please call the Nurse if you have any questions (510) 644-6859]. I believe I understand the benefits and risks of the vaccine and request that this vaccine be given to me or to the person named on this record for whom I am authorized to make this request.

PLEASE CHECK ONLY ONE:

- ☐ I give consent for the **series** of vaccinations needed.
- ☐ I give consent **ONLY** for the vaccines required immediately and wish to be consulted before further vaccines are given.

_____ _____

Parent/Guardian Signature Date

Please complete the reverse side

1980 Allston Way, H-105 Berkeley, California 94704 • 510 644-6965 • Fax: 510 644-2887 • TDD: (510) 981-5373

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Student's Name:_____

DOB:_____

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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 us to explain it.	yes	no	don't know
1. Is the student sick today?	☐	☐	☐
2. Does the student have allergies to medications, latex, eggs, or other foods?	☐	☐	☐
3. Has the student had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the student 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 student, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
6. Does the student have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
7. 9. In the past 1–3 months, has the student 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 student received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. Is the student pregnant or is there a chance they could become pregnant during the next month?	☐	☐	☐
10. Has the student received vaccinations in the past 4 weeks?	☐	☐	☐

_____ _____

Parent/Guardian Signature Date

Please complete the reverse side

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