VACCINATION CONSENT FORM

King's Daughters Medical Center Clinic

King's Daughters Medical Center ("KDMC", "we" or "us") will offer a series of vaccinations to the sixth-grade students at **Boyd County** during the course of the **2016/2017**school year. The vaccinations to be offered to protect against the following conditions:

1. Tetanus-Diphtheria-Pertussis ("TDAP") – Tetanus, diphtheria and pertussis are bacterial diseases that cause muscle pain, difficulty breathing, vomiting and a host of other symptoms, and can lead to serious health problems including but not limited to lockjaw, paralysis, heart failure and death. The TDAP vaccine is typically given in 1 dose (by shot). Potential side effects include but are not limited to soreness at the injection site, fever, headache, rash, body-aches or nausea.

2. Varicella ("Chickenpox") – Chickenpox is a very contagious disease that causes a blister-like rash, itching, tiredness, and fever. The Chickenpox vaccine is typically administered in 2 doses (each a shot). Potential side effects include but are not limited to soreness or swelling at the injection site, fever, mild rash, seizure or pneumonia.

3. Meningococcal ("Meningitis") – Meningitis is a serious bacterial illness, which can lead to infection of the lining of the brain and spinal cord and infections of the blood. The Meningitis vaccine is typically administered in 2 doses (each a shot). Potential side effects include but are not limited to redness or soreness at the injection site or mild fever.

In order to receive a vaccination for any of the above conditions, Student must this Vaccination Consent Form in addition to a separate Consent for Services form on file at school, both completed and signed by Student's parent or legal guardian.

Please complete this form and indicate which vaccinations you wish for Student to receive. Please sign below as Parent/Guardian if you give permission to KDMC to administer the selected vaccinations to Student.

Student Information

School District: _____ School: _____

Student Name: _____ Birthdate: _____

Is Student in Foster Care? ❑ Yes ❑ No

If Yes, list name and agency of social worker: _____

Medical Questionnaire

Is Student taking any medications (over-the-counter or prescription)? ❑ Yes ❑ No

If Yes, list medications:_____

Does Student have any allergies? ❑ Yes ❑ No

If Yes, please list:_____

Does Student have a moderate or severe illness today? ❑ Yes ❑ No

Has Student had a severe allergic or other reaction to a previous dose of any of the selected vaccinations? This would include an allergic reaction to the combined vaccination for MMR and Chickenpox, known as the "MMRV" vaccination. ❑ Yes ❑ No

Does Student have cancer or a disease that affects the immune system? ❑ Yes ❑ No

Is Student being treated with drugs that affect the immune system, such as steroids, or receiving cancer treatment with radiation or drugs? ❑ Yes ❑ No

Selection of Vaccinations

Using your initials below, please select the vaccinations you wish for Student to receive.

_____ TDAP _____ Chickenpox _____ Meningitis

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By my signature below, I certify the following:

- **I was provided with, and have read and understand, the vaccine information statements related to the selected vaccinations, and I have also read and understand the description of each selected vaccination contained in this Vaccination Consent Form;**
- **I was given the opportunity to ask questions about the risks and benefits of the selected vaccinations;**
- **I have been informed that as a result of the selected vaccinations Student may experience some side effects including but not limited to the side effects described on the first page of this Vaccination Consent Form;**
- **I agree that the information provided herein is true and accurate to the best of my knowledge; and**
- **I give my consent for Student to receive the selected vaccinations (all doses, if applicable).**

Parent/Guardian Name (Printed):_____

Parent/Guardian Signature and Date:_____