



Vaccine Clinic Registration and Consent Form

Student's Name _____

Students Date of Birth _____ Student's School _____

Student's MassHealth Number _____

Parent's Name _____

Phone Number _____ Email address _____

Please answer the following questions by checking Yes or No

	Yes	No
1. Does your child have a disability?		
2. Does your child feel sick today?		
3. Does your child have an allergy to medication, food, a vaccine ingredient or latex?		
4. Does your child have a history of seizures?		
5. Does your student have any history of myocarditis or pericarditis?		
6. Does your child or the child's parent/sibling have an immune system problem?		
7. Has your child had an allergic reaction to another vaccine?		
8. In the past 6 months, has your child taken any medication that affects the immune system?		
9. Is your child on long-term aspirin therapy?		

	Yes	No
10. During the past year, has your child received a blood or blood product transfusion, been given immune (gamma) globulin, or taken an antiviral drug?		
11. Is your student pregnant or could they become pregnant in the next month?		
12. Has your child received any vaccines in the last 4 weeks?		
13. Does your child have any of the following conditions?		
a. A history of Guillain-Barre Syndrome		
b. A problem with their heart		
c. A problem with their lungs		
d. A problem with their kidneys		
e. Diabetes		
f. Asthma		
g. A blood clotting disorder		
h. No spleen		
i. A cochlear implant		
j. A spinal fluid leak		
k. Cancer, leukemia, or HIV/Aids		
l. Wheezing		
m. Take medication that affect the immune system		

By completing and submitting this form, I confirm that I am the appropriate parent, guardian, or legally authorized individual to provide consent and I attest to:

- A. I authorize Framingham Public Schools to administer the vaccinations listed below to my child.
- B. I understand that Framingham Public Schools is not acting as my child's medical provider and any questions related to my child's vaccinations should be directed to my pediatrician or preferred medical provider.
- C. I give permission for FPS to share with MassHealth records and information concerning my child(ren) and their health-related services, as necessary. I understand that this will help our community seek partial reimbursement of MassHealth covered services.

Parent Signature: _____

Vaccinations Needed:

Vaccine	Date	Location	Lot Number

Nurse Name: _____ Date: _____

Nurse Signature: _____

Notes: