DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT

Fisher Building • 3011 West Grand Blvd. • Detroit, MI 48202

detroitk12.org

Vaccine Consent Form

Student Name: _____ Birth date: _____ Age: _____

Street Address: _____ City, State, Zip: _____

Telephone: _____ Male Female (circle one)

School Name: _____ Grade: _____

VFC Eligibility:

Insurance Type (circle): **Private Medicaid No Insurance Under-insured American Indian/Alaskan Native**

Parent/Guardian Name: _____

CONSENT FOR VACCINATION: Detroit Public Schools Community District (DPSCD) will review my child's information in the Michigan Care Improvement Registry (MCIR). Based on the information in MCIR, I authorize the DPSCD to administer all recommended or needed vaccines for his/her age. This consent form authorizes the administration of multiple doses of a vaccine, as medically indicated. Combination vaccines will be used as available, unless contraindicated.

I have read and understand the Vaccine Information Statement(s) available online at MDHHS - Vaccine Information Statements (VIS) (michigan.gov) for the recommended vaccine(s). I understand the benefits and risks of the recommended vaccine(s) and I understand the immunization(s) administered is entered into MCIR. This consent form will expire after the last vaccination is given in a vaccine series.

Parent/Guardian Signature _____ **Date** _____

Please check Yes or No	**Yes**	**No**
Does the child have any allergies to medication, food, a vaccine component, or latex?		
Has the child had a serious reaction to a vaccine in the past?		
Has the child had a health problem with lung, heart, kidney, or metabolic disease (diabetes), asthma, or a blood disorder? Is he/she on long term aspirin therapy?		
Has the client, a sibling, or a parent had a seizure? Has the client had brain or other nervous system problems?		
Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
In the past 3 months, has the client taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?		
In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
Is the client pregnant or is there a chance she could become pregnant during the next month?		
Has the client received vaccinations in the past 4 weeks?		
Has the client received a TB skin test this month?		

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PLEASE NOTE!!!!! VACCINE REFUSAL SECTION BELOW			
COMPLETE SECTION BELOW IF YOU DO NOT WANT YOUR CHILD TO RECEIVE A VACCINE			
VACCINE REFUSAL: Place a check next to the vaccine(s) that you **do not** want your child to receive and **sign.**			
□ DTaP/Tdap/Td	□ Pneumococcal	□ Meningococcal ACWY	□ Polio
□ Hib	□ MMR	□ Influenza	□ HPV
□ Hepatitis A	□ Hepatitis B	□ Men B	□ Varicella

My child, as named above, should not receive the above vaccines as indicated by a check mark. I understand the possible consequence(s) of not allowing my child to receive the recommended vaccines.

Parent/Guardian Signature _____ **Date** _____