Fisher Building • 3011 West Grand Blvd. • Detroit, MI 48202
detroitk12.org

DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT

# 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 and/or its School-Based Health Center Partners 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 understood 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:** _____

**For Staff Use Only:**

## Verbal Consent for Vaccination

Name of DPSCD Staff Member Making the Call:

_____

Name of Parent or Guardian: _____

Date: _____

Time: _____

Parent/Guardian has provided authorization for DPSCD and/or its School-Base Health Center Partners to Provide Vaccines to the student. Please circle the appropriate answer. (Yes) (No)

Additional Comments: _____

_____

**Students Rise. We all Rise**