HEALTH 4 CHICAGO
UNIVERSITY OF CHICAGO • UNIVERSITY OF ILLINOIS

ADOLESCENT VACCINATIONS

This form is to be completed by the parent or legal guardian of the child named below.

STUDENT INFORMATION

Last Name:	First Name:	Grade:
Date of Birth:	❑Male ❑ Female	School:
Home Address:		ZIP Code:
City of Residence:	Parent/legal guardian full name:	
Daytime Phone:	Mobile:	I am the student's: ❑ Parent ❑Legal guardian
Email address (If available):		

HEALTH SCREENING

Has your child ever had a **severe** reaction to a vaccine? ❑ No ❑ Yes- describe:

Does your child have any **severe** allergies to medications, food, **eggs**, or latex? ❑ No ❑ Yes- describe:

Does your child have a condition that lowers immunity (cancer, leukemia) ❑ No ❑ Yes- describe:

Is your child taking medication that lowers immunity (cortisone, other steroids, radiation)? ❑ No ❑Yes- describe:

Is your child currently receiving aspirin therapy? ❑ No ❑ Yes- describe:

Has your child been diagnosed with asthma or experienced recurrent wheezing? ❑ No ❑ Yes- describe:

Is your child pregnant or nursing? ❑ No ❑ Yes

Please check with your doctor if you are unsure of medical details. Please let us know about any changes in your child's medical condition on the day of vaccination.

CONSENT FOR VACCINATION

I have read and understand the information provided to me about the vaccinations listed below, including risks and side effects.
I GIVE CONSENT for my child, named at the top of this form, to get vaccinated with the vaccines I have checked below during the 2013-2014 academic year. I further understand the School that my child attends (named above) is not liable for the services or vaccinations administered by Health4Chicago.

YES, I GIVE MY CONSENT for my child to receive the recommended vaccine(s) I have checked below:

Influenza (Flu) Vaccine ❑ Flu Shot: Injection ❑ Flu Mist: Nasal

❑ Tetanus, Diphtheria and Pertussis (Tdap) ❑ Meningococcal vaccine (Meningitis) ❑ Human papillomavirus (HPV) -3 doses over 6 months

❑ **NO,** I **DO NOT** consent for my child to receive recommended vaccines. REASON:

HEALTH INSURANCE

❑ MY CHILD DOES NOT HAVE INSURANCE

Name of Insured:		Insured's Date of Birth:
Medicaid #:		
Insurance (non-Medicaid):		Type: ❑ PPO ❑ HMO
Insurance ID #:	Group #:	Employer:

INTERNAL USE ONLY

Vaccine	Date Administered	Site/ Route (Circle One)	Lot Number (Place Sticker)	Immunizer
		RA IM LA IM IN		
		RA IM LA IM IN		
		RA IM LA IM IN		
		RA IM LA IM IN		

I opt out of my child's information being entered into the Illinois Comprehensive Automated Immunization Registry Exchange, which allows Illinois providers access to my child's immunization records. ❑

I agree to assign insurance benefits to the treating physician. Medical information may be released to my insurance company for the purposes of securing payment for services received. I understand it is my responsibility to understand my benefits and insurance coverage and I will be held responsible for any fees owed for services. **Children uninsured or covered by Medicaid will be given vaccines FREE of charge to parents**.

Parent/Guardian Signature **Date**

COMPLETE THE FOLLOWING PAGE →