Evergreen Family Medicine School Exclusion Day Vaccine Event

Student Name: _____

DOB: _____

Evergreen FAMILY MEDICINE
A Division of Centennial Medical Group

According to school and state records, your child is due for the immunizations checked below. Please indicate next to each one if you would like your child to receive that specific vaccine at school during the school exclusion day event. If you do not want your child to receive any vaccines during this event, you do not need to return this form.

☐ Tdap (required) Yes / No

☐ Meningococcal (recommended) Yes / No

☐ _____

☐ HPV (recommended) Yes / No

☐ *Flu (recommended) Yes / No
**while supplies last*

Screening Checklist for Contraindications to Vaccines for Children & Teens

1 Is your child sick today? Yes / No

2 Does your child have allergies to a vaccine component or latex? Yes / No

3 Has your child had a serious reaction to a vaccine in the past? Yes / No

4 Has your child had brain or other nervous system problems? Yes / No

5 **For Females: Is your child pregnant?** Yes / No

By signing this form, you have received and/or read the Vaccine Information Statement (VIS) for each vaccine to be given, and that you give permission for them to be administered and the insurance you provide below to be billed.

"I understand the benefits and risks associated with the vaccines to be given and request the vaccines indicated to be given to my child for whom I am authorized to make this request."

Sign: _____ Date: _____

Printed Name: _____ Relation to child: _____

Child's insurance information:

If child has OHP for primary insurance, please write their SSN here:

For all other primary insurance:

Name of insured parent/guardian: _____ Date of birth: _____

Address: _____

Name of insurance company: _____

Insurance company address: _____

Insurance company phone / fax #: _____

Insurance company group & ID #: _____