Anchorage School District
Healthcare Services Department

General Vaccine Consent

LAST NAME	FIRST NAME	MI	DATE OF BIRTH
STREET ADDRESS			GENDER
CITY	STATE	ZIP CODE	PHONE
RACE ☐ Alaska NativeAmerican Indian ☐ Asian ☐ Black/African American ☐ Multiracial ☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ White ☐ Other:			ETHNICITY ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
MOTHER'S MAIDEN NAME *(if 18 or younger)*	SCHOOL *(if ASD student)*		GRADE *(if ASD student)*

VACCINE ELIGIBILITY

One box from this section must be selected to be eligible to receive a free vaccine

CHILDREN (6 months through 18 years of age)

- ☐ Medicaid or Denali Kid Care *(VFC Medicaid Eligible)*
- ☐ No medical insurance *(VFC Uninsured)*
- ☐ Native American or Alaska Native *(VFC American Indian/Alaska Native)*
- ☐ Insured *(State Vaccine AVAP)*
- ☐ Underinsured *(State Vaccine AVAP)*

ADULTS (19 years of age and older)

- ☐ Insurance that covers vaccines *(State Vaccine AVAP)*
- ☐ Other *(Private Vaccine)*

HEALTH SCREEN QUESTIONNAIRE

Please answer the questions below. Your answers will be used to determine if it is safe to administer immunizations today. If you answer "YES" to any of these questions, an ASD nurse will review your health information. In some instances, a nurse cannot administer a vaccine unless you have a medical provider's note stating it is safe for you to be immunized.

	YES	NO
Are you sick today?	○	○
Do you have allergies to medications (e.g. antibiotics), food, a vaccine component, or latex?	○	○
Have you been diagnosed with Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?	○	○
Have you had a serious reaction to a vaccine in the past?	○	○
Do you have any long-term health problems including lung, heart, kidney, metabolic (e.g., diabetes), and/or a blood disorder?	○	○
Have you had a seizure, brain or other nervous system problem?	○	○
Do you or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problem?	○	○
In the past 3 months, have you taken medications that affect the immune system such as prednisone, other steroids, or anticancer medications; medications rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	○	○
In the past year have you received a blood transfusion, blood products (e.g. plasma), or been given immune (gamma) globulin?	○	○
Are you currently taking any antiviral medications, for example those used to suppress the herpes virus?	○	○
Are you pregnant or planning to become pregnant in the next month?	○	○
Have you received vaccinations in the past 4 weeks?	○	○

CONSENT FOR VACCINATION

The most current Vaccine Information Sheet (VIS) has been made available for me to read. I understand their contents and hereby consent to receive (or for my child to receive) the vaccine. I understand this consent will be valid for the number of doses recommended. YES, I give authorization for the nurse to review and enter the administration into VacTrAK, a vaccination record system managed by the State of Alaska, Department of Health and Social Services, Section of Epidemiology.

NAME *(parent/guardian if person is under 18 years old)*	RELATIONSHIP TO MINOR *(if 18 or younger)*
SIGNATURE	DATE SIGNED

This consent is valid for: ☐ DTaP ☐ DTaP/HepB/Polio ☐ Hep A ☐ Hep B ☐ IPV ☐ MMR ☐ Tdap ☐ Varicella

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VACCINATION RECORD – FOR NURSE USE ONLY				
Vaccine	**Date Administered**	**Route and Site**	**Lot Number Exp Date VIS Date**	**Vaccinator Name Signature / Title**
DTaP *(Less than 7 years old)*		☐ IM - Right Deltoid ☐ IM - Left Deltoid ☐ IM - Right anterolateral thigh ☐ IM - Left anterolateral thigh	Lot#: Exp Date: VIS Date:	
DTaP/HepB/ Polio *(Less than 7 years old)*		☐ IM - Right Deltoid ☐ IM - Left Deltoid ☐ IM - Right anterolateral thigh ☐ IM - Left anterolateral thigh	Lot#: Exp Date: VIS Date:	
Hep A		☐ IM - Right Deltoid ☐ IM - Left Deltoid ☐ IM - Right anterolateral thigh ☐ IM - Left anterolateral thigh	Lot#: Exp Date: VIS Date:	
Hep B		☐ IM - Right Deltoid ☐ IM - Left Deltoid ☐ IM - Right anterolateral thigh ☐ IM - Left anterolateral thigh	Lot#: Exp Date: VIS Date:	
IPV		☐ IM - Right Deltoid ☐ IM - Left Deltoid ☐ SQ - Right Upper Arm ☐ SQ - Left Upper Arm	Lot#: Exp Date: VIS Date:	
MMR		☐ SQ - Right Upper Arm ☐ SQ - Left Upper Arm	Lot#: Exp Date: VIS Date:	
Tdap *(7 years and older)*		☐ IM - Right Deltoid ☐ IM - Left Deltoid ☐ IM - Right anterolateral thigh ☐ IM - Left anterolateral thigh	Lot#: Exp Date: VIS Date:	
Varicella		☐ SQ - Right Upper Arm ☐ SQ - Left Upper Arm	Lot#: Exp Date: VIS Date:	