

**Explanation of Procedure**

The Minneapolis Health Department School Based Clinics Program keeps this record in your medical file (or your child's medical file). The information contained within this record is being maintained to monitor immunization needs in order to prevent disease. If personal information is requested and not provided, immunization services may be denied. This information is private and will not be shared with anyone except the Minnesota Department of Health and licensed health care professionals such as doctors, nurses, health insurers, schools, child care facilities, Health Start programs, county public health agencies, community action agencies; or licensed health care facilities such as hospitals in order to assess and/or provide immunization services or to facilitate future enrollment in a child care facility, school, or college. Your immunization records will be given to Immulink, a statewide registry, for this purpose.

If you choose not to have this information included in the registry, please check this box.

**Vaccine Administration**

Many vaccines require two (2), three (3), four (4), or five (5) doses to provide complete protection. These include **Td** (tetanus/diphtheria); **Tdap** (tetanus, diphtheria, acellular pertussis); **IPV** (injectable polio vaccine); **MMR** (measles, mumps, rubella); **Hep B** (hepatitis B vaccine); **MCV4** (meningococcal conjugate vaccine); and **HPV** (human papillomavirus); **Hep A** (hepatitis A vaccine).

The following vaccine doses are being recommended by the provider:

Hep A:  1  2    Hep B:  1  2  3    HPV:  1  2  3    Influenza:  1    IPV:  1  2  3  4  
 MCV4:  1    MMR:  1  2    Td:  1  2  3  B    Tdap:  1  2  3  B

**Acknowledgement** *by signing below, you acknowledge the following:*

I have been given a copy and have read or have had explained to me the information contained in the appropriate vaccine information materials (fact sheets) about the disease(s) and vaccine(s) indicated above.

I have had a chance to ask questions that were answered to my satisfaction.

I believe I understand the benefits and risks of the indicated vaccine(s) and ask that the vaccine(s) checked above be given to me or to the person named below.

Furthermore, if the person named below is a minor child, I attest that I am the child's parent, authorized representative, or legal guardian and may provide effective consent for this immunization.

\_\_\_\_\_  
Student Name *please print*

\_\_\_\_\_  
Student Signature *if over 18 years of age*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian name *please print*

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Immunization Contradiction Review**

**Febrile illness/Active infection/Fever > 101**  Yes  No    **Serious reaction to vaccine in the past?**  Yes  No

**IPV**  
**Patient has had a pregnancy?**  Yes  No    **Allergy to neomycin, streptomycin, polymyxin B?**  Yes  No

**MMR & Varicella**  
**Allergy to gelatin?**  Yes  No    **Allergy to neomycin?**  Yes  No  
**Pregnancy?**  Yes  No *You must not now be pregnant and should not get pregnant for 4 weeks. If you have intercourse, use effective birth control methods.*  
**Immunosuppression of patient?**  Yes  No

**Hep B**  
**Allergy to baker's yeast?**  Yes  No

**Influenza**  
**This is my first flu shot**  Yes  No  
**Allergy to eggs, chicken products, Thimerosal (preservative), gentamicin, arginine, or any component of the flu vaccine?**  
 Yes  No  
**I have a fever today.**  Yes  No    **History of Guillian Barre Syndrome?**  Yes  No  
**I take a prescription blood thinner:**  Yes  No Name: \_\_\_\_\_

**TDaP**  
**Allergy to Latex?**  Yes  No    **History of epilepsy/seizer or nervous system problem?**  Yes  No  
**History of Guillian Barre Syndrome?**  Yes  No