



<b>PERSONAL INFORMATION</b>			Year of Graduation: _____	
School Student Attends: _____			Date of Birth: ____/____/____	
Print Student Name	First: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Last: _____	Street Address: _____	City: _____	St: _____	Zip: _____
Print Parent/Guardian Name: _____			Daytime Phone #: _____	

**HEALTH INSURANCE INFORMATION**

Name of Insurance Company: \_\_\_\_\_

Member Id: \_\_\_\_\_ Group # (if applicable): \_\_\_\_\_

No Insurance

**MEDICAL SCREENING FOR VACCINE ELIGIBILITY**

- Does your child have allergies to medications, food, or any vaccine? Y / N If yes, list: \_\_\_\_\_
- Has your child ever had a serious reaction to a vaccine in the past? Y / N If yes, explain: \_\_\_\_\_
- Has your child, a sibling, or a parent ever had a seizure or brain problem? Y / N
- Does your child have cancer, leukemia, HIV/AIDS, or any other immune system condition? Y / N
- Does your child take cortisone, prednisone, steroids or anti-cancer drugs or had radiation treatment? Y / N
- Received a blood transfusion, blood products, or been given immune (gamma) globulin in the past year? Y / N
- Has your child received any vaccinations in the past 4 wks or taken an antiviral drug? Y / N If Y, List: \_\_\_\_\_

**CONSENT FOR VACCINATION IN SCHOOL SETTING**

I have viewed the Vaccine Information Statement(s) for the vaccine(s) requested at <http://www.immunize.org> or obtained a hard copy by calling the Rhode Island Department of Health at 401-222-5960. I understand the benefits and risks of the vaccine(s) requested.

I understand that a record of vaccinations administered in this program will be submitted to the statewide database, KIDSNET within 48 hrs of vaccination. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine.

<b>PARENT SIGNATURE REQUIRED NEXT TO EACH VACCINE REQUESTED:</b>		<b>Vaccination History</b> <i>List Dates If Available</i>
HEP A _____	DATE: _____	Dose #1 _____ #2 _____
HEP B _____	DATE: _____	Dose #1 _____ #2 _____ #3 _____
HPV _____	DATE: _____	Dose #1 _____ #2 _____ #3 _____
MMR _____	DATE: _____	Dose #1 _____ #2 _____
MENINGITIS (MCV4) _____	DATE: _____	Dose #1 _____ #2 _____ #3 _____
MENING B _____	DATE: _____	Dose #1 _____ #2 _____ #3 _____
POLIO _____	DATE: _____	Dose #1 _____ #2 _____ #3 _____
TDAP / TD _____	DATE: _____	DOSE# : _____ Td: _____ Td: _____
CHICKEN POX _____	DATE: _____	Dose #1 _____ #2 _____ DATE DX: _____

*The vaccine(s) checked should be given to the student named for whom I am authorized to make this request. I understand that all doses indicated for each vaccine are needed to receive full protection.*