

COMPLETE BOTH SIDES OF THIS FORM

Name of School Student Attends:				Student's Grade	
Last Name (Please Print)	First Name	MI	Date of Birth	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Street Address (include Apt # if applicable)			City	State	Zip
Parent/Guardian – Please PRINT Name		Daytime Phone Number		Cell Phone Number	
Insurance:					
<input type="checkbox"/> Blue Cross Blue Shield# _____					
<input type="checkbox"/> UnitedHealthcare# _____ Group #: _____					
<input type="checkbox"/> Tufts# _____					
<input type="checkbox"/> Neighborhood Health Plan# _____					
<input type="checkbox"/> Cigna# _____					
<input type="checkbox"/> Other					
<input type="checkbox"/> No Insurance					
Race: (Check one or more) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native					
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Unknown or Other Race _____					
Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown					

IMMUNIZATION SCREENING QUESTIONNAIRE

Parent/Guardian: Please circle the answers to the questions below to help us determine which vaccines may be given.

- Does your child have allergies to medications, food, or any vaccine? Yes No
If yes, please explain: _____
- Has your child ever had a serious reaction to a vaccine in the past? Yes No
If yes, to what vaccine and when? _____
- Has your child ever had a seizure or brain problem? Yes No
If yes, please indicate current status: _____
- Does your child have leukemia, AIDS, or any other immune system condition? Yes No
- Does your child take cortisone, prednisone, other steroids or anti-cancer drugs, or has he/she had x-ray treatment in the past three months? Yes No
- Has your child received a blood transfusion, blood products, or been given a medicine called immune (gamma) globulin in the past year? Yes No
- Has your child received any vaccinations in the past 4 weeks? Yes No
If yes, which vaccine(s) _____

Student's name: _____ Student's date of birth: _____

VACCINATION HISTORY OBTAIN INFORMATION FROM PHYSICIAN	PLEASE SIGN IF VACCINE IS NEEDED
HEPATITIS B (3 shots) _____ Date Vac #1 Date Vac #2 Date Vac #3	HEPATITIS B: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I understand that 3 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE HEPATITIS B VACCINE(S) Signature: _____ Date: _____
MMR (2 shots) _____ Date Vac #1 Date Vac #2	MMR: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I understand that 2 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE MMR VACCINE(S) Signature: _____ Date: _____
TDAP Td _____ Date Vaccine Date Vac #2	TDAP: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE TDAP VACCINE Signature: _____ Date: _____
MENINGITIS _____ Date Vac #1 Date Vac #2 Date Vac #3	MENINGITIS: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE MENINGITIS VACCINE Signature: _____ Date: _____
CHICKENPOX _____ Date Vac #1 Date Vac #2 _____ Date Had Chickenpox	CHICKENPOX: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I understand that 2 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE CHICKENPOX VACCINE(S) Signature: _____ Date: _____
POLIO (3-4 shots) _____ Date Vac #1 Date Vac #2 Date Vac #3 _____ Date Vac #4	POLIO: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I understand that 3-4 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE POLIO VACCINE(S) Signature: _____ Date: _____
HPV (3 shots) _____ Date Vac #1 Date Vac #2 Date Vac #3	HUMAN PAPILOMAVIRUS VACCINE: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I understand that 3 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE HPV VACCINE(S) Signature: _____ Date: _____
HEPATITIS A (2 shots) _____ Date Vac #1 Date Vac #2	HEPATITIS A: I have viewed the Vaccine Information Statement at http://www.immunize.org or obtained a hard copy by calling The Health Information Line at 222-5960. I understand that 2 shots are needed for full protection. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine. I PERMIT MY CHILD TO BE GIVEN THE HEPATITIS A VACCINE(S) Signature: _____ Date: _____

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