MOBILE COUNTY HEALTH DEPARTMENT
SCHOOL IMMUNIZATION CONSENT

Information about person to receive vaccine (Please print)			
Name: Last First M.I.	D.O.B.	Age	
Social Security Number Phone	Race/Ethnicity	Sex M F	
Address: Street City State Zip			
☐Yes ☐No Allergies? ___ ☐Yes ☐No History of adverse reactions to vaccines?			
Required school immunizations for children greater than 10 years old. MMR Varicella IPV T-Dap			

Information about responsible party (Please print)	
Name: Last First M.I.	D.O.B.
Social Security Number	Phone
Address: Street	
City State Zip	

Copies of the Vaccine Information Statement(s) and the Notice of Privacy Practices are available online: www.MobileCountyHealth.org and will be available during each school clinic. I have read and understand the Vaccine Information Statement(s) and have had the opportunity to discuss any questions or concerns with the provider (690-8991).
I give permission for my child to receive the vaccine(s) required for school entry.

Signature ___ Date ___

Vaccine:	Vaccine:	Vaccine:	Vaccine:
Manufacturer:	Manufacturer:	Manufacturer:	Manufacturer:
Lot Number:	Lot Number:	Lot Number:	Lot Number:
Injection Site: LA/RA IM/SQ	Injection Site: LA/RA IM/SQ	Injection Site: LA/RA IM/SQ	Injection Site: LA/RA IM/SQ

NURSE'S NOTES	
Signature and Title of Vaccine Administrator:	Provider Stamp:

MCHD-IMM-106 (REV. 10/2010)