BERKELEY HIGH SCHOOL HEALTH CENTER
1980 Allston Way, Rm. H-105 (510) 644-6965

IMMUNIZATION SCREENING /CONSENT FORM

(COMPLETE BOTH SIDES OF FORM)

Child's Name: _____ Date of Birth ____/____/____

Address: _____

Phone: _____

MY CHILD HAS THE FOLLOWING MEDICAL COVERAGE:

- ☐ No health insurance
- ☐ Medi-Cal/Healthy Families
- ☐ Have insurance but immunizations are not covered
- ☐ Have insurance but have difficulty getting immunizations due to copay/deductible
- ☐ Other

THE FOLLOWING VACCINES ARE REQUIRED/ RECOMMENDED FOR YOUR CHILD:

- ☐ Hepatitis A (HEP A)
- ☐ Hepatitis B (HEP B)
- ☐ Human Papillomavirus (HPV VAC)
- ☐ Inactivated Poliovirus (IPV)
- ☐ Measles/Mumps/Rubella (MMR)
- ☐ Meningococcal Conjugate (MCV)
- ☐ Tetanus/Diphtheria (Td, adult)
- ☐ Tetanus/Diphtheria/Acellular Pertussis (Tdap)
- ☐ Varicella (Chickenpox)

CONSENT:

I have read or have had explained to me the information provided about the vaccine(s) requested above. I have had an opportunity to ask questions which were answered to my satisfaction. [Please call the clinic if you have any questions (510) 644-6859] I believe I understand the benefits and risks of the vaccine and request that this vaccine be given to me or to the person named on this record for whom I am authorized to make this request.

PLEASE CHECK ONLY ONE:

- ☐ **I give consent for the series of vaccinations needed.**
- ☐ **I give consent ONLY for the vaccines required immediately and wish to be consulted before further vaccines are given.**

_____ _____ _____

Signature Relation to Student Date