Sacramento City Unified School District

Meningococcal Screening and Consent Form

NOTE: **If your child has been given a MCV4 vaccine at age 16 or later, there is no need for another Meningococcal vaccine. Child who receives first dose at age 11 through 12 will need booster dose at age 16, if first dose given between 13 and 15, booster needed at age 16 through 18 years.**

Please Read The Following Carefully Before Signing

For you/your child to be eligible to receive Meningococcal vaccine, **you must read, answer all questions, and sign this consent form**. Your answers to the questions listed below will help determine if you/your child will be able to receive the Meningococcal vaccine. Please read the Meningococcal Vaccine Information Statement provided.

NAME: ______________________ (First) ______________________ (Last) BIRTHDATE: ______________ (mm-dd-yyyy) AGE: ______ SEX: Male or Female

PARENTS PHONE: (   )____________ ADDRESS:______________________________ CITY:______________ ZIP: _______

Please circle **Yes** or **No** for the following questions **and** answer **ALL** questions.

Question		
1) Has the person received a Meningitis Vaccine before? ________ If so, when?	Yes	No
2) Does the person have any serious allergies to medications, food, latex or other substances?	Yes	No
3) Has the person ever had a bad reaction to a vaccine in the past? If yes, please explain: ______________________________	Yes	No
4) Are you feeling well today?	Yes	No
5) Does the person have sickle-cell disease, or a damaged spleen, or has the spleen been removed?	Yes	No
6) Does the person have any medical conditions (including pregnancy) for which she/he is seeing a doctor regularly? (If pregnant please bring a note from your doctor in order to receive vaccination).	Yes	No

I have been given a copy of the Vaccine Information Statement for the Meningococcal vaccine (VIS, 10/14/11). I believe I understand the benefits and risks of the vaccine and request that the vaccine indicated above be given to me or to the person named above for whom I am authorized to sign.

______________________________ ______________________________ ______________

Signature **Printed Name** **Date**

Parent's Information – Please print clearly.

Mother's First and Last Name: ______________________________

Father's First and Last Name: ______________________________

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FOR CHILDREN 18 AND YOUNGER ONLY. Please complete the following questions for our record keeping.	Yes	No
Is the child American Indian or Alaskan Native?		
Is the child covered by CHDP or Medi-Cal?		
Does the child have private health insurance?		
Is the child covered by Healthy Families?		

Date:	Vaccine / Mfg:		Lot # Exp. Date:		Screening MD/RN/LVN	IZ Given By:	Route/ Site
	MCV4 0.5 mL	SP	U4055BA	6-14-13			IM LD RD