

2025 ADOLESCENT VACCINATION CONSENT FORM (Tdap, HPV, Meningococcal ACWY)



Date of Birth:	Name:	· · · · · · · · · · · · · · · · · · ·	First		C.111	Health Depar	tment Use	Only
If minor - parent/guardian's name: Last Parent's SSN:						Cli ID #:		
If Immore - parente glaration is name: Law Fisa M.I. Parent'S Card M.I. Parent' Guardian's Date of Birth: // Parent's SSN: City: ZIP: Crade: Bornel Guardian's Date of Birth: // Parent's SSN: City: ZIP: School: IMPORIANT Parent'Guardian Phone # Home: Cell: Work: Emergency Contact: (If other than Head of Household) My child will be 11 years of age or older on the day of the scheduled vaccination clinic: YES NO Please check YES or NO to all the questions below to determine if your child can receive offered vaccines at school. The nurse giving the vaccine will review this information on the day of the vaccine clinic. YES NO Has your child ever had a serious reaction to any vaccine component or yeast? Has your child ever had a serious reaction to a previous dose of Tdap, HPV, or Meningococcal vaccine in the past? Did your child experience a coma, decreased level of consciousness, or long or multiple seizures within seven days Glolwing a dose of DTP, DTaP, Dr. Or Td, or ever had Guillain-Barré Syndrome (GBS)! If so, consult your doctor about receiving 11 by your child pergenant? If yes, vaur child will not receive the HPV vaccine, but may receive the other vaccines at school. If you child have seizures or another neceive the HPV vaccine, but may receive the other vaccines at school. If you child has a severe life-first acting allerge, please speak with your child? So dotor before consenting to vaccination. NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS BOR CTESTING. VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice: I fray DTH health care professional, worker or employees should be directly expected to your child blood or body fluids in a way that may transmit disease, the preson's blood will be directly exposed to blood or body fluids for a VDH health care professional, worker or employee in a way that may transmit disease, the provider will cell you that person the result of the test. *Note: Vaccines will be prov					- 1	Encounter #		
Parent's SSN: City:	If minor - parent/guar	dian's name:	Last	Firet	М I	Effective ii.		
Address: Grity: ZIP:								
Emergency Contact:	Address:			City:		ZIP:		
Emergency Contact:	Grade:	Home Room Tea	cher:			School:		_
My child will be 11 years of age or older on the day of the scheduled vaccination clinic: YES NO	IMPORTANT Parent/	Guardian Phone # Hor	me:	Cell:	V	Vork:		
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I authorize VDH to release records necessary to support the application for payment by Medicare. Medicaid, and other health care benefits. I	() is Ameri () has Med Molina H Member II () has Med () has other Pol Attach a Insuranc	can Indian or is an Alas icaid MCO with: Senta ealthcare, United Healt D# as shown on your ca icaid or FAMIS (circle r insurance not listed ab icy ID # a copy of the front & b e company address	ka Native ara Community Car cheare Community I ard: one) that is not a M ove (specify plan r ack of insurance of	re, Anthem Healthkee Plan, or Aetna Better ICO plan: Medicaid aname) Policy heard or provide the f	pers Plus, Health (circle is this a FAM older's name_ following infor	your plan) filS plan? □Y □N rmation:	-	

Office of Privacy and Security

Authorization for Disclosure of Protected Health Information

This consent gives the Virginia Department of Health (VDH) permission to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to my child cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that immunization records of my child will be retained for 21 years after birth.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.
- ☐ Please check box if you wish to receive a copy of the Virginia Department of Health Notice of Privacy Practices.

CONSENT FOR CHILD'S HPV VACCINATION: ☐ My child has NEVER been vaccinated for HPV. Note: Your child will require two doses: the first dose now and the 2 nd Dose 6 months after Dose 1. NOTE: children with certain medical conditions may require three doses. Please consult your provider to assess the need for a third dose. ☐ My child has received the first dose of the HPV vaccine. Note: the 2 nd Dose should be received 6 months after Dose 1.										
I have read the 2021 Vaccination Information Statement (VIS) for the HPV Vaccine. I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the HPV vaccine (shot) If needed, I give my consent for my child to receive the second dose approximately six months after the first dose.										
Signature of Pare	ent or Legal Guard	ian: X			Date:/					
CONSENT FOR CHILD'S MenACWY VACCINATION: I have read the 2025 Vaccination Information Statement (VIS) for the MenACWY Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the Meningococcal ACWY vaccine (shot). Signature of Parent or Legal Guardian: Date:/										
CONSENT FOR CHILD'S Tdap VACCINATION: I have read the 2025 Vaccination Information Statement (VIS) for the Tdap Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the Tdap vaccine (shot). Signature of Parent or Legal Guardian: Date:/										
Please send a copy of my child's immunization record to her/his doctor at the following address.										
Doctor's NameMailing AddressCityStateZIP				ZIP						
HEALTH DEPARTMENT USE ONLY										
Date	Item code	Fund Source	Lot Number		inistration Site	Provider #				
	Tdap-	VFC STF		RA	LA					
	MCV4-	VFC STF		RA	LA					
	HPV9 #1	VFC STF		RA	LA					
	HPV9 #2	VFC STF		RA	LA					
		VFC STF		RA	LA					
Comments										
Provider Name/Signature and Date										