Newark High School- School-Based Health Center
750 East. Delaware Ave 19711

Date: _____ Child's Name: _____ DOB: _____

Dear Parent or Guardian:

Please check one vaccine box

☐ Diphtheria, Tetanus, Pertussis (Tdap)/Td ☐ Hepatitis B ☐ Human Papillomavirus (HPV)

☐ Meningococcal (MCV4) ☐ Meningococcal (Men B) ☐ Hepatitis A ☐MMR ☐IPV(Polio)

☐Seasonal Flu OTHER: _____

Immunization guidelines have been established by the Division of Public Health to determine eligibility for students to receive vaccinations against some diseases through the School-Based Health Centers (SBHC). In order for your child to receive vaccinations through the SBHC, Please complete sections I and II.

Please note that the SBHC and the Division of Public Health believe the best way for your child to be vaccinated is through your Primary Health Care Provider (physician). Please sign the vaccine administration record on the back of this form to acknowledge you have received the vaccine information sheet.

SECTION I

I would like my child to be vaccinated at the SBHC due to the following:

1. Cannot get to the doctor for reasons such as costs, lack of transportation, missed time at school.
   Please write in your reason:_____
2. The next available appointment time with the doctor will prevent my child from meeting a deadline such as school entry or athletic activity.
3. My child does not have a family doctor or other health care provider. (Explain, we may be able to help)

_____

SECTION II (VFC Patient Eligibility Screening Record)

In addition to the item that I checked in Section I, my child **(check all that apply in Section II):**

4. Is age 18 or younger
5. Is enrolled in Medicaid.
6. Does not have health insurance.
7. Is an American Indian or Alaskan Native.
8. Is insured by **Delaware Healthy Children Program**
9. Is insured by **CHAP (Community Healthcare Access Program)**
10. Has other insurance that covers vaccinations.
    Please write in the name of the insurance:_____

If your child has health insurance that does not pay for vaccinations you must go to one of the following centers:

Henrietta Johnson Medical Center, Wilmington (302) 655-6190
Westside Health Services, Wilmington (302) 655-5822

I agree that the above information is true and accurate. I have been given a copy of appropriate Centers for Disease Control & Prevention vaccine information materials and have read, or have had explained to me, information about the diseases and vaccine. I believe I understand the benefits and risks of the vaccines discussed as set forth in the materials I received and I consent to having the above vaccine given to my child. I understand that if my child is vaccinated in the SBHC, a record of his/her vaccinations will be sent to his/her family doctor if he/she has one.

Name of Doctor: _____

_____ _____

Signature of Parent/Guardian Date

Vaccine Administration Record

PATIENT NAME: _____
DATE OF BIRTH: _____
PROVIDER NAME: _____
ADDRESS: _____
CITY, STATE, ZIP: _____

(Provider's stamp)

***SITE ROUTE LEGEND**
RA= *Right Arm*
LA= *Left Arm*
RT= *Right Thigh*
LT= *Left Thigh*
PO= *Oral*
IM= *Intramuscular*
SQ= *Subcutaneous*

CIRCLE VACCINE	DATE GIVEN M/D/Y	SITE/ ROUTE	VACCINE		VACCINE INFORMATION STATEMENT (VIS)		VACCINATOR (signature or initials & title)	PARENT/ GUARDIAN/ SIGNATURE/ DESIGNEE INITIAL BELOW	VFC ☐ YES
			LOT#	MFR.	DATE ON VIS	DATE GIVEN			
DTaP DTaP/Hepb/IPV DT									
DTaP DTaP/Hepb/IPV DT									
DTaP DTaP/Hepb/IPV DT									
DTaP DT									
DTaP DTaP/IPV DT									
Hep A					10/15/2021				
Hep A									
Hep B					10/15/2021				
Hep B									
Hep B									
Hib HepB/Hib DTaP/Hib/IPV									
Hib HepB/Hib DTaP/Hib/IPV									
Hib HepB/Hib DTaP/Hib/IPV									
Hib DTaP/Hib/IPV									
HPV					8/6/2021				
HPV									
HPV									
Influenza					8/6/2021				
Influenza									
IPV - Polio					8/6/2021				
IPV									
IPV									
IPV									
Meningo Conj (MCV4)					8/6/2021				
Meningo Conj (MCV4)									
Meningitis B					8/6/2021				
Meningitis B									
MMR MMRV					8/6/2021				
MMR MMRV									
PCV 13									
PCV 13									
PCV 13									
PCV 13									
Td					8/6/2021				
Td Tdap					8/6/2021				
Varicella									
Varicella									
Other:									

DELAWARE HEALTH AND SOCIAL SERVICES **Division of Public Health Immunization Program 1-800-282-8672**

Revised 8/10/2021

VIS Dates Revised 8/10/2021

PARENTS PLEASE INITIAL ABOVE NEXT TO EACH VACCINE YOU WOULD LIKE YOUR CHILD TO RECEIVE.

THEN PLEASE ON NEXT PAGE SIGN YOUR SIGNATURE. WE DO NOT CARRY THE VARICELLA/HIB OR DTAP VACCINE.