

REGISTRATION AND CONSENT FORM - IMMUNIZATIONS
CHILDREN'S NATIONAL MEDICAL CENTER

Dear Parent or Guardian:

PLEASE READ AND COMPLETE CAREFULLY
PLEASE RETURN TO THE SCHOOL NURSE/CHILD CARE PROVIDER

PRINT Name of Child to receive VACCINE(S)			
Last	First	Middle	Date of Birth
Street Address Apt#			
City Washington,	State DC	Zip Code	
Parent or Guardian: Please PRINT your name Daytime phone or pager Number, in case of emergency.			

Alternate Authorized Representative/Proxy
<p>I _____ am the parent or legal guardian of the child listed above. I am unable to physically accompany my child (listed above) during the vaccine service. Therefore, I grant permission to _____ (insert name) to serve as the Alternate Authorized Representative (AAR) to approve qualification for vaccines as indicated by the current immunization record from the DC Immunization Registry or the attached immunization record. I certify that the AAR is at least 18 years of age. Please note that the AAR may be a principal/executive director, teacher, teacher assistant, health aide, or family member.</p>

"I have been given a copy and have read or had explained to me the information in the appropriate CDC Vaccine Information Materials (VIMs) about the vaccine(s) indicated below. I have had a chance to ask questions that were answered to my satisfaction. **I believe that I understand the benefits and risks of the indicated vaccines and ask that the vaccine(s) checked below be given to me or the person named above for whom I am authorized to make this request.** I understand that some vaccines may require more than one dose and that my child will receive the required shots at the recommended time to complete the series. I understand that this information may be stored in the DC Immunization Program's Central Immunization Registry."

This immunization screening is a service for your child to be immunized at his/her school/child care center. Your child's immunization record will be reviewed by a trained staff person to determine the vaccines need. If you consent to your child being vaccinated according to the DC Immunization Program's Central Immunization Registry or by a copy of your child's immunization record that you have provided, please sign below. Thank you.

- | | | | |
|--|--|---|--|
| _ DTP/DTaP/Td/Tdap #1
_ DTP/DTaP/Td/Tdap #2
_ DTP/DTaP/Td /Tdap#3
_ DTP/DTaP #4
_ DTP/DTaP #5

_ HPV VACCINE #1
_ HPV VACCINE #2
_ HPV VACCINE #3

_ Td/Tdap Booster

_ Hib VACCINE #1 | _ Hib VACCINE #2
_ Hib VACCINE #3
_ Hib VACCINE #4

_ Flu VACCINE #1
_ Flu VACCINE #2
_ POLIO VACCINE #1
_ POLIO VACCINE #2
_ POLIO VACCINE #3
_ POLIO VACCINE #4

_ MMR #1 VACCINE
_ MMR #2 VACCINE | _ HEPATITIS B #1VACCINE
_ HEPATITIS B #2VACCINE
_ HEPATITIS B #3VACCINE

_ VARICELLA (Chickenpox)
VACCINE #1
_ VARICELLA (Chickenpox)
VACCINE #2
(Vaccine not required if already had
the disease)

_ PNEUMO CONJ 7 #1 | _ PNEUMO CONJ 7 #2
_ PNEUMO CONJ 7 #3
_ PNEUMO CONJ 7 #4
_Meningococcal

_OTHER _____
_OTHER _____

Please mark here if:
<input type="checkbox"/> Had CHICKENPOX disease
When: _____ |
|--|--|---|--|

- NO RECORD ON FILE. Use student's immunization records, if provided or administer age-appropriate vaccine(s) based on immunization schedule.**
- My child has received these Shots. (Records attached)**
- Yes, I would like for my child to receive the Influenza Vaccine (Flu Shot)**

SIGNATURE of Parent or Guardian _____ /Print _____

If you have questions/concerns, please call Dr Bear's Express at 202-207-8990



