Clinic Use Only	Assessment Notes:	Vaccines:
VFC/MC VFC/No Ins PVT Ins ARx CAIR PVT Rec New Returning	PHC/CIN # _____ Active DOS _____ Provider _____	

CHILD VACCINE CONSENT FORM

Child's First Name

Child's Last Name

Child's Date of Birth mm/dd/yyyy

Age

Child is ○ Female ○ Male ○ Non-Binary ○ Prefer Not to Say

Home Address

City

State

Zip Code

Mother's Maiden Name*

Parent/Guardian Name

Parent/Guardian Phone #

*Used for help identify child in vaccine registry

Child's Race and Ethnicity - Choose all that apply

○ Asian ○ Black or African American ○ Hispanic or Latina ○ Native American/Alaskan Native
○ Native Hawaiian or Other Pacific Islander ○ White ○ Other

MEDICAL QUESTIONS - ALL MUST BE ANSWERED. Explain all yes answers. **Yes** **No**

1) Does your child have any allergies to medications, food, a vaccine component, or latex? _____ ☐ ☐
2) Has your child had a serious reaction to a vaccine in the past?_____ ☐ ☐
3) Has your child had brain or other nervous system problems? Or immunocompromised?_____ ☐ ☐
4) For females: Is your child pregnant or is there a chance she will become pregnant in the next month?_____ ☐ ☐
5) Is the child sick today?_____ ☐ ☐
6) Has the child had any vaccines in the last 4 weeks? If yes, which vaccine(s)_____ ☐ ☐

Any additional information not listed:

Which Vaccine(s) do you want your child to receive? Circle all that apply

Rotavirus	MMR (measles, mumps, rubella)	Meningococcal B	Influenza
DTap	Varicella (chickenpox)	RSV - Beyfortus	Other _____
Hepatitis B	Tdap	Hepatitis A	
Polio	HPV	Pneumococcal	
Hib	Meningococcal ACWY	Covid	

I hereby give my consent to AndersonRx to administer the vaccine(s) I have requested and discussed above. I understand the risks and benefits associated with the vaccine(s) and have read or had explained to me the CDC's Vaccine Information Statement (VIS). I acknowledge that I have read or received a copy of the AndersonRx Notice of Privacy Practices and that I can also access a complete copy at www.andersonrxpharmacy.com. I authorize AndersonRx to submit my child's vaccination to the California Immunization Registry (CAIR2), which is run by the CA Department of Public Health and regulated under CA law AB1797.

Printed Name (**REQUIRED**)

Signature of Name (**REQUIRED**)

Date (**REQUIRED**)

Your relationship to child:

○ Mother ○ Father ○ Guardian

○ Other: ⇨ STOP and speak with vaccinator

Office use only: Licensed Provider's Recommendation for CHW Services- See Beneficiary Information Above

Licensed Provider's NPI:_____ Provider's Name:_____

Provider's Signature:_____

Type of CHW/P/R Services Needed: Vaccine Other Notes:_____