

**NM SCHOOL IMMUNIZATION - CONSENT FORM**

Please Print Clearly, Use CAPITAL LETTERS ONLY

FIRST NAME  Social Security Number (optional)  -  -

LAST NAME  DATE OF BIRTH

Mother's Maiden NAME

Mailing Address

CITY  STATE  ZIP CODE

Mail completed top form to:  
NM Immunization Program  
PO Box 26110  
Santa Fe, NM 87502-6110

Please fill circles COMPLETELY

**Sex**  
 Male  
 Female

**Ethnicity**  
 Hispanic  
 Non-Hispanic

**Race**  
 Native American  
 Asian  
 Black or African-American  
 White  
 Other

I have been given and have read, or have had explained to me, the information in the 'Vaccine Information Statement(s)' for the disease(s) and vaccine(s) checked below. I believe I understand the benefits and risks of the vaccines requested and ask that the vaccine(s) checked below be given to me or the the person named for whom I am authorized to make this request. I understand that some shots are given in a series over a period of time and that by signing this form I agree that the shots marked below will be given, including those needed to complete a series. I agree to report any problems that arise, and direct any questions I may have to the School Nurse. I also understand that I may request from the School Nurse procedures on how to lawfully discontinue a series once begun. I agree to allow information on immunizations given to me or to the named person to be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. I also understand that my medical care provider may release this information to the state immunization registry (NMSIIS) unless I sign a document indicating my refusal.

Client or guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR SCHOOL NURSE ONLY (Enter numbers and fill appropriate circles completely)**

Chart #  Date of Service        VFC PIN # (if VFC)

For children 0-18 years, VFC category that applies:  
 Native American  
 Private insurance  
 Salud/Medicaid or CHIP  
 Has no health insurance

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**Vaccine:**  
 DT  HepB  HPV  MMR  Td  
 DTaP  HepB 2-dose  Influenza  MMRV  Tdap  
 HepA  Hib  MCV4  Polio  Varicella

Lot #  Injection Site

Manufacturer:  Sanofi Pasteur  Merck  Other  
 GlaxoSmithKline  Wyeth

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Provider of vaccine: \_\_\_\_\_ Date: \_\_\_\_\_