BURRILLVILLE MIDDLE SCHOOL

2220 Bronco Highway, Harrisville, RI 02830

Mr. Dennis Kafalas
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Principal

Ms. Raechel M. Robidoux
robidouxr@bsd-ri.net
Assistant Principal

Mustang Country

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Middle School Health Office

Attached is a form for the **"Vaccinate Before You Graduate"** program. This program provides convenience for students to catch up to required vaccines and is arranged through the R.I. Department of Health and The Wellness Company. We are offering this convenience here at Burrillville Middle School!

The Wellness Company will be here to deliver vaccination services in school on May 11th. Our focus in May is to provide students with the opportunity to *complete the HPV series* that may have been started in the pediatrician's office.

If you are interested in this opportunity, please complete the attached form so your child can receive the next HPV vaccination on May 11th during school hours. Please take this opportunity to complete the HPV series.

Note: This is a no cost to you. Please complete health insurance information if your child has coverage, if not, please leave blank.

Please return the completed form as soon as possible.

Thank you,

Diana McPherson,
School Nurse-Teacher

Vaccinate before you Graduate

VACCINE CONSENT FORM

RHODE ISLAND DEPARTMENT OF HEALTH

PERSONAL INFORMATION School Student Attends:			Year of Graduation:
Print Student Name Last:	First:	☐ Male ☐ Female	Date of Birth: _____/_____/_____
Street Address:	City:	St:	Zip:
Print Parent/Guardian Name:			Daytime Phone #:

HEALTH INSURANCE INFORMATION

Name of Insurance Company: _____

Member Id: _____ Group # (if applicable): _____

☐ No Insurance

MEDICAL SCREENING FOR VACCINE ELIGIBILITY

1. Does your child have allergies to medications, food, or any vaccine? Y / N If yes, list: _____
2. Has your child ever had a serious reaction to a vaccine in the past? Y / N If yes, explain:
   _____
3. Has your child ever had a seizure or brain problem? Y / N
4. Does your child have leukemia, AIDS, or any other immune system condition? Y / N
5. Does your child take cortisone, prednisone, steroids or anti-cancer drugs? Y / N
6. Received a blood transfusion, blood products, or been given immune (gamma) globulin in the past year? Y / N
7. Has your child received any vaccinations in the past 4 weeks? Y / N If yes, which vaccine(s):_____

CONSENT FOR VACCINATION IN SCHOOL SETTING

I have viewed the Vaccine Information Statement(s) for the vaccine(s) requested at http://www.immunize.org or obtained a hard copy by calling the Rhode Island Department of Health at 401-222-5960. I understand the benefits and risks of the vaccine(s) requested.

I understand that a record of vaccinations administered in this program will be submitted to the statewide database, KIDSNET within 48 hrs of vaccination. I hereby release The Wellness Company from any and all liability associated with the administration and potential side effects of the vaccine.

PARENT SIGNATURE REQUIRED NEXT TO EACH VACCINE REQUESTED:

			Vaccination History ***List Dates If Available***
HEP A	X_____	**DATE:**_____	DOSE #1_____#2 _____
HEP B	X_____	**DATE:**_____	DOSE #1_____ #2 _____ #3_____
HPV	X_____	**DATE:**_____	DOSE #1_____#2_____ #3 _____
MMR	X_____	**DATE:**_____	DOSE #1_____ #2 _____
MENINGITIS	X_____	**DATE:**_____	DOSE #1_____ #2 _____ #3_____
POLIO	X_____	**DATE:**_____	DOSE #1 _____ #2 _____ #3 _____
TDAP / TD	X_____	**DATE:**_____	TDAP: _____ TD: _____ TD: _____
CHICKEN POX	X_____	**DATE:**_____	DOSE #1 _____ _ #2_____ DATE DX:_____

The vaccine(s) checked should be given to the student named for whom I am authorized to make this request. I understand that all doses indicated for each vaccine are needed to receive full protection.

Return This Form To Your School Nurse