

School-Based Immunization Consent Form

Student Information

Full Name

Date of Birth

School Name

Grade

Parent/Guardian Information

Parent/Guardian Name

Relationship to Student

Phone Number

Email

Immunization Consent

Vaccines to be administered:

- ☐ DTP
- ☐ MMR
- ☐ HPV
- ☐ Others

I give my consent for the student named above to receive the selected immunizations.

☐ Yes ☐ No

Allergies or Medical Conditions

Emergency Contact Name

Emergency Contact Phone

Parent/Guardian Signature

Date