Vaccination Date_________________

Universal Consent and Screening Form for Minors age 6 months through 17 years

SECTION 1: INFORMATION ABOUT MINOR CHILD TO RECEIVE VACCINE (PLEASE PRINT)

<table>
<tr><td>MINOR'S NAME (Last)</td><td>(First)</td><td>(Middle Initial)</td><td colspan="2">MINOR'S DATE OF BIRTH (MM/DD/YEAR):</td></tr>
<tr><td colspan="3">MINOR'S RACE
☐White ☐Black or African American ☐ Asian
☐Native American or Alaska Native
☐Native Hawaiian or Pacific Islander</td><td>ETHNICITY
☐Hispanic
☐Non-Hispanic</td><td>Is Minor a person with a disability?
☐Yes
☐No</td></tr>
<tr><td>PARENT/LEGAL GUARDIAN'S NAME
(Last)</td><td>(First)</td><td>(Middle Initial)</td><td>MINOR'S AGE</td><td>MINOR'S SEX
☐Male
☐Female</td></tr>
<tr><td colspan="3">ADDRESS</td><td colspan="2">PARENT/GUARDIAN DAYTIME PHONE NUMBER <u>AND</u> MOBILE NUMBER:</td></tr>
<tr><td>CITY</td><td>STATE</td><td>ZIP</td><td colspan="2">PARENT/GUARDIAN EMAIL:</td></tr>
</table>

Primary Insurance Plan Name:_________________________________ Policyholder Name: ___________________________________

Member or Policy Number:___________________ Policyholder relationship to the patient:___________________________________

SECTION 5: CONSENT. I understand the risks and benefits of the ____

____ **Vaccine(s). In providing my consent below, I agree that:**

1. I have read, or had read to me, the age-applicable *Fact Sheet for Recipients and Caregivers* or *Vaccine Information Statement* for the Vaccine(s) the minor child named above is being authorized to receive, as listed in Section 5 above.
2. I have the legal authority to consent to have the minor child named above vaccinated.
3. I am not required to accompany the child named above to their vaccination appointments and that, by giving my consent below, the child may receive the Vaccine(s) whether or not I am present.
4. If I have health insurance that covers the child named above, I give permission for my insurance company to be billed for the costs and/or administration of the Vaccine(s).
5. I understand that pursuant to state law, all immunizations will be entered into the Louisiana Immunization Network (LINKS) registry operated by the Louisiana Department of Health. More information about LINKS can be found at: https://ldh.la.gov/index.cfm/page/3660.

I GIVE CONSENT to ____ [INSERT VACCINATING ENTITY NAME] to vaccinate the minor child named above with the vaccines listed in Section 5 above.

Date: Month ____ Day _____ Year ______

Signature of the Parent/Legal Guardian (named above): ____

FOR CLINIC USE ONLY

This child qualifies for vaccination through the VFC program because he/she (check only one box); or ☐ is not qualified

(a) is enrolled in Medicaid	(b) does not have health insurance	(c) is American Indian or Alaskan Native

I certify that the Important Information Statement(s) for the vaccine(s) indicated as administered below were presented to the person or parent /guardian named above at this clinic and on the date shown here.

Clinic Name:	Date Vaccinated:	Signature and Title of the Vaccine Administrator:

Vaccine	Manufacturer	Lot#	Expiration Date	Route	Dose	Injection Site	EUA/VIS Date
DTaP DT Td DTaP-Hib Tdap							
IPV							
MMR							
HIB							
HBV							
HAV							
VARICELLA							
PPSV/PCV							
FLU							
JYNNEOS							
COVID-19							
OTHER							
OTHER							

Entered into LINKS (initial and date) ___________________________Notes/Comments: ____

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