DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

School-Based Health Center
Childhood Vaccination Consent Form

Use this form to give permission to medical providers at a DC School-Based Health Center to administer required vaccinations and COVID-19 vaccinations. DC Law requires each student attending a DC public school, public charter school, private school, or independent school to be immunized in accordance with current Department of Health requirements. **This form does not replace the District of Columbia Universal Health Certificate. Updated school heath forms can be found on the DC Health website at: https://dchealth.dc.gov/service/school-health-services-program.**

The Immunization of School Students Act of 1979 (DC Law 3-20) requires that to attend school in the District of Columbia all students shall provide their school with proof of immunization, unless the student has received a medical or religious exemption pursuant to DC Official Code § 38-506.

In response to disruptions from the Covid-19 epidemic, vaccination services are available for all DCPS enrolled students at any DC School-Based Health Center and is not dependent on the student's enrollment at that center. After the mass vaccination period is over, School-Based Health Centers will only be available to students enrolled in the designated Health Center and their children.

Patient Personal Information | Completed by parent/guardian/student

Student Last Name:	**Student First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ❑ Male ❑ Female ❑ Non-Binary	
Home Address:	**Apt:** **City:** **State:**	**ZIP:**
Ethnic Designation: *(check all that apply)*	❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino ❑ Other ❑ Prefer not to answer	
Race: *(check all that apply)*	❑ American Indian/ Alaska Native ❑ Asian ❑ Native Hawaiian/ Pacific Islander ❑ Black/African American ❑ White ❑ Prefer not to answer	
Parent/Guardian Name:	**Parent/Guardian Phone:**	
Emergency Contact Name:	**Emergency Contact Phone:**	
Insurance Type: ❑ Medicaid ❑ Private ❑ None	**Insurance Name/ID #:**	

I give permission to the signing health examiner/facility to share the health information on this form with the student's school, childcare, or appropriate DC Government agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Official Code § 38-651 (DC Law 17-107), except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and submitted before the student can receive vaccination services.

Signature:_____ **Date:** _____

Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)*

Vaccination Permission | Completed by parent/guardian/student

I give permission to the signing health examiner/facility to administer vaccinations to the student in line with the DC Department of Health school immunization requirements. I understand that immunization is required to attend school under DC Law 3-20 unless the student has received a medical or religious exemption. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Official Code §38-651 (DC Law 17-107), except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and submitted before the student can receive vaccination services.

Signature:_____ **Date:**_____

Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)*

Immunization Provided | Completed by School-Based Health Center staff.

Student Last Name:	Student First Name:				Date of Birth		
Immunizations	**Provide in the boxes below the dates of Immunization (MM/DD/YY)**						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Patient had Chicken Pox (month & year):				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
COVID-19 Vaccination	1	2	3	4	5	6	7
Other	1	2	3	4	5	6	7

❑ This child is **behind on Immunizations** and there is a plan in place to get them back on schedule. **Next Appointment is**_____

Medical Exemption (if applicable)

I certify that the above patient has a valid medical contraindication(s) to being immunized at the time against:

❑ Diphtheria ❑ Tetanus ❑ Pertussis ❑ Hib ❑ HepB ❑ Polio ❑ Measles ❑ COVID-19

❑ Mumps ❑ Rubella ❑ Varicella ❑ Pneumococcal ❑ HepA ❑ Meningococcal ❑ HPV

Alternative Proof of Immunity (if applicable)

I certify that the above patient has laboratory evidence of immunity to the following and I have attached a copy of the titer results.

❑ Diphtheria ❑ Tetanus ❑ Pertussis ❑ Hib ❑ HepB ❑ Polio ❑ Measles ❑ COVID-19

❑ Mumps ❑ Rubella ❑ Varicella ❑ Pneumococcal ❑ HepA ❑ Meningococcal ❑ HPV

I hereby certify that I have administered the vaccinations indicated above to the patient.

This form does not replace the District of Columbia Universal Health Certificate (UHC). Parents/guardians are required to submit both this form and the UHC to their child's school.

Provider Name: _____ **Provider Signature:** _____

Provider Phone: _____ **Date:** _____

Licensed Health Care Provider Office Stamp