Immunization Consent for Persons Under 18
(please fill in blanks neatly)

I, (parent name)_____, state that I am the Parent or Legal Guardian of:

Student's Name _____; Social Security Number _____,
(*please include both name and SSN for positive identification of participant)*

a student at _(school)_____, and

that I have signed this Consent for the purpose of authorizing Maxim Health Systems, LLC, to provide my son/daughter/charge with the following immunizations:

☐ Influenza ☐ Pneumococcal ☐ Tdap ☐ Meningitis ☐ Hepatitis B

A vaccine, like any medicine, could cause a serious reaction. But the risk of a vaccine causing serious harm, or death, is extremely small.

INFLUENZA VACCINE ADVERSE REACTIONS: soreness, redness, or swelling where the shot was given. Hoarseness; sore, red or itchy eyes; cough, fever, aches.

PNEUMONIA VACCINE ADVERSE REACTIONS: redness or pain where the shot is given. Fever, muscle aches, or more severe local reactions.

Tdap VACCINE ADVERSE REACTIONS: redness or pain where the shot is given. Mild fever, headache, tiredness, nausea, vomiting, diarrhea, stomach ache, chills, body aches, sore joints, rash, or swollen glands (uncommon).

MENINGITIS VACCINE ADVERSE REACTIONS: redness or pain where the shot is given. S small percentage of recipients may develop a fever.

HEPATITIS B VACCINE ADVERSE REACTIONS: soreness where the shot is given, fever.

CONSENT. I believe the benefits of my son/daughter/charge receiving this vaccine outweigh the risks and I herby provide informed consent to Maxim for administration of the vaccine(s) noted above. I understand that, at the time vaccination is administered, my son/daughter/charge will complete a separate Consent and health questionnaire in preparation for the vaccination and that they will be responsible for completing those health-related questions and executing that Consent form.

RELEASE. I, for myself and my child/charge hereby release Maxim, school, school district, physician and/or medical director and their respective parent, affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with or in any way related to the participant's receipt of this or these immunization(s). Maxim and the other aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above.

DISCLOSURE OF HEALTH INFORMATION. I understand that Maxim may provide a copy of both consents for services to the educational institution for inclusion in my son's/daughter's medical record and that Maxim may further use/disclose personal and health information to treat participants in its vaccine programs, to receive payment for the care it provides, and for other health care operations. I understand that Maxim has developed a Notice of Privacy Practices which outlines its policies and practices in regards to protecting, using and disclosing personal health information, which can be viewed at [insert website].

Parent/Guardian Signature _____ Date _____

Please fax this form to ATTN: FLU COORDINATOR at 888.265.4199