# CCHD Student Immunization Form

**School: _____**

*Date:* _____ ☐ *Male* | ☐ *Female* | *Phone Number:* _____
*First Name*: _____ *Middle*: _____ *Last Name*: _____
*DOB*: _____| *Preferred Language*: ☐ English ☐ Spanish ☐ Other: _____
*Address*: _____ *City*: _____ *State*: _____ *Zip:* _____
*Ethnicity:* ☐ Non-Hispanic or Latino ☐ Hispanic or Latino
*Race:* ☐ White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Pacific Islander
*Method of Payment*: ☐ Self-Pay ☐ Medicaid ☐ Private Insurance – please fill out spaces below.
*Insurance Name:* _____ S*ubscriber Name:* _____
*Subscriber ID:* _____ *Subscriber DOB:* _____

**Medical Information**
Known allergies or medical conditions:
_____

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**Consent**
I am the parent or legal guardian of the student named above. I authorize Christian County Health Department to administer the recommended vaccine(s) to my child during the school immunization clinic.
I acknowledge that I have received or had access to vaccine information, have had the opportunity to ask questions, and understand that, as with any medical treatment, side effects may occur. I authorize appropriate medical care if needed in the event of an adverse reaction.
**Parent/Guardian Signature: _____**
**Printed Name: _____**
**Date: _____**

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**For Clinic Staff Only**
**Vaccine(s) Administered:**

- _____
- _____
- _____
- _____

**Nurse: _____**