

IMMUNIZATION PERMISSION FORM
Sixth Grade School Site MCV/Tdap Immunization Initiative

Please complete both sides of this form and return to your child's school no later than April 1, 2026.

VACCINATION AUTHORIZATION

- Yes, I give permission for my child to receive the **MENINGOCOCCAL CONJUGATE VACCINE (MCV)** as indicated at school. I have read the attached *Vaccine Information Sheet* for MCV and have had my questions answered.
- Yes, I give permission for my child to receive the **TDAP VACCINE** as indicated at school. I have read the attached *Vaccine Information Sheet* for Tdap and have had my questions answered.

INFORMATION ABOUT YOUR CHILD

Child's Legal Name:			Date of Birth:		
Age:	Sex:	Race:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
School:		Grade:	Teacher:		
Home Address:					
City:			State:	ZIP:	
Phone Number:					
Mother's Name:			Father's Name:		
Guardian (if under 18):			Emergency Contact Name:		
Guardian's relationship to child:			Emergency Contact Phone:		

This child has allergies to: _____

Has this child had a serious reaction to a vaccine in the past? Yes No

Has this child, a sibling, or a parent ever had a seizure? Yes No

Has this child had a brain or other nervous system problem? Yes No

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Transylvania Public Health's privacy notice is available at transylvaniahealth.org/stayontrack. Your signature below acknowledges that we have given you a copy of our Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us.

Initial all that are true:

_____ I have received Transylvania County's Privacy Notice.

_____ I have been given a chance to discuss my concerns and questions about the privacy of my health information.

AUTHORIZING SIGNATURE

 Patient Signature (Parent/Guardian Signature if patient under 18)

 Date

(please complete both sides)

