VACCINE INFORMATION AND CONSENT

Your child may need immunizations which will be administered in the clinic. As with any medicine, vaccines have a small risk of side effects. Potential side effects associated with each vaccine as reported by the Centers for Disease Control (CDC) can be found through vaccine information statements listed on the following website: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. We administer the following recommended vaccines to our patients:

- **Diphtheria, Tetanus, and Pertussis (DTaP)**
- **Chickenpox (Varicella)**
- **Haemophilus Influenza Type B (Hib)**
- **Measles, Mumps, and Rubella (MMR)**
- **Pneumococcal Polysaccharide Vaccine**
- **Hepatitis A or B**
- **Polio (IPV)**
- **Tetanus and Diphtheria (Td) or Tetanus, Diphtheria, and Pertussis (TDaP)**
- **Influenza**
- **Meningococcal**
- **HPV**

****NOTE: ALL REQUIRED AND RECOMMENDED VACCINATIONS WILL BE GIVEN UNLESS OTHERWISE SPECIFIED BY THE PARENT OR GUARDIAN.**

OVER THE COUNTER MEDICATIONS (OTC)

No OTC medications will be given without consent on file. The following list of OTC medications can be administered by the school nurse after examination and assessment as per physician approved protocols:

- **Pain Relief: Tylenol, Advil**
- **Allergy Symptoms: Claritin, Benadryl**
- **First aid solutions: Betadine, Eye Wash Solution, Hydrogen Peroxide, Isopropyl Alcohol, Saline**
- **Stomach Ache: Children's Pepto Bismol, Tums**
- **Rash or Skin Irritation: Hydrocortisone Cream**
- **Anti-infectives: Neosporin, Silvadene Cream for burns**

****NOTE: GENERIC BRANDS MAY BE SUBSTITUTED**

CLINIC SERVICES

By signing the consent, you acknowledge that services provided may include, without limitation: physical exams, evaluation and treatment of common illnesses, management of chronic health conditions, first aid, blood/urine tests, medication administration, vaccinations, chronic disease management, social services, fluoride varnishes, vision/hearing/dental screening, health and safety education, subspecialty referrals, nutrition evaluation/counseling, mental health screening/counseling, psychology consultation, tuberculosis testing, adolescent health services, telemedicine services. A letter will be sent home with your child notifying you when services were provided.

CONSENT BY PARENT OR GUARDIAN TO TREAT THE STUDENT

I, the parent or guardian of _____, agree for my child to receive the above services. By signing this University of Miami consent to treatment form, I acknowledge that the above services will be provided to my child without limitation. I also understand that this consent will remain in effect for the duration of enrollment in the school or until I notify the school nurse in writing of any changes, including, without limitation, any newly developed or diagnosed conditions or other changes in the child's health condition. If I do not wish to have specific services for my child, I will notify the school nurse in writing.

I would like to opt out of the following vaccines or services for my child**:** _____

_____	_____	_____	_____
Parent/Guardian Signature Parent/Guardian Name (Print)	Parent/Guardian Signature Parent/Guardian Name Signature	Date	Time

For further information contact Dr. John T. Macdonald School Health Initiative at 305-243-6131.