

Central Coast VNA & Hospice  
**MENINGOCOCCAL IMMUNIZATION  
PREPAYMENT/CONSENT FORM**

**PLEASE PRINT**

Student Name: \_\_\_\_\_ (Last) \_\_\_\_\_ (First)

Date of Birth: \_\_\_\_\_ School Name: \_\_\_\_\_

Parent's (or Guardian's) Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

\_\_\_\_\_ I would like my son/daughter to receive the Meningococcal [Groups A, C, Y and W-135] Polysaccharide Diphtheria Toxoid Conjugate) Vaccine

\_\_\_\_\_ I have enclosed a check in the amount of \$130.00, made to VNA.

If you have any questions, please call the Immunization Information Line, (831) 648-3777 or Immunization Coordinator at (831) 372-6668 ext. 2119.

**Pregnant students, students with acute illness, students with an allergic reaction to thimerosal, latex or students with a bleeding disorder when the vaccine is to be given should NOT participate in the program.**

*Please complete the bottom of this authorization form if the student is under age 18 and the parent or guardian will not be present at the time of the vaccination.*

-----  
**FOR STUDENTS UNDER 18 YEARS OF AGE**

Informed Consent to Administer

I, the undersigned, authorize the nursing staff at VNA to administer Meningococcal [Groups A, C, Y and W-135] Polysaccharide Diphtheria Toxoid Conjugate) Vaccine to my son or daughter in an effort to provide immunization against meningococcal disease.

I understand that this vaccine is safe and that the meningitis vaccine can provide protection against four of the five strains of the disease (serogroups A, C, Y, and W-135; there is currently no vaccine for serogroup B.) The most common side effects in clinical trials of the vaccine included soreness, redness or swelling at the vaccination site. These symptoms were mild, did not require treatment and did not last more than 48 hours.

I have read the literature provided, which outlines the benefits of the meningococcal vaccine as well as the possible side effects.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_