UNIVERSITY of SOUTH FLORIDA
Student Success
Student Health & Wellness Center

Parental Consent for Minors for Administration of Vaccines

I/We,_____,

the [ ] parent(s)
[ ] legal custodian(s);
[ ] legal guardian(s) of the following minor(s):

_____ _____
Student's Name and U number DOB

Hereby give authorization for administration of the following vaccines:

- MMR and/or Menactra (MCV4 – A,C, Y, W-135)

by health care providers affiliated with the University of South Florida (USF) Student Health & Wellness Center, USF Counseling Center, and the USF Physicians Group.

Consent is only valid if signed and dated by both the Parent/Legal Custodian/Legal Guardian and a Witness that is **over the age of 18.**

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Print Name of Parent/Legal Guardian Date

Please mail or fax this completed form to: Student Health & Wellness Center
University of South Florida
4202 E. Fowler Ave., SWC 310
Tampa, FL 33620
Fax: 813-974-5888