



## 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 healthcare providers affiliated with the University of South Florida (USF) Student Health & Wellness Center, USF Counseling Center, and the USF Physicians Group

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