CORPUS CHRISTI INDEPENDENT SCHOOL DISTRICT
(CCISD)
Voluntary Student COVID-19 Vaccination

PARENT/GUARDIAN/ADULT STUDENT CONSENT AND RELEASE AUTHORIZATION

STUDENT: **(Name and Address)**

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SCHOOL CAMPUS: ______________________________

DATE(s): SCHOOL YEAR __________________________

I am ___ the Parent/Guardian of the above-named Student who is under eighteen years of age or ___ I am an Adult Student of majority age listed above, and am fully competent to sign this Consent and Release Authorization.

To fully protect CCISD students from the COVID-19 pandemic, CCISD desires to offer voluntary vaccines to students at their school campuses; which will be administered by trained medical personnel subject to parental consent and release authorization.

I hereby give consent for the above named Student to receive all available Covid-19 vaccines during the school year. I acknowledge that the Covid-19 vaccines may expose Student to hazards or risks that may result in Student's illness, personal injury or death and I understand and appreciate the nature of such hazards and risks.

In consideration of Student being permitted to receive the Covid-19 vaccinations, I hereby accept all risk to Student's health and of his/her injury or death that may result from such vaccinations. I hereby release CCISD, its governing board, officers, employees and representatives from any and all liability to Student, Student's Parent/Guardian, Student's personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to Student, and for any and all illness or injury to Student, including his/her death, that may result from or occur to Student.

I HAVE CAREFULLY READ THIS DOCUMENT AND UNDERSTAND IT TO BE A CONSENT AND RELEASE AUTHORIZATION OF ALL CLAIMS AND CAUSES OF ACTION.

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Signature of Parent/Guardian/Adult Student

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Address (if different than Student)

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Date Signed