School Immunization Clinic Parental Consent Form

School Name ______________________ Clinic Date ______________________

In order for your child to obtain the adolescent vaccinations during this school based clinic, you must
1. **Complete** both sides of this form, 2. **Provide** previous vaccination records, and 3. **Sign & Date** this form.

A. Information about Person Receiving Vaccine (Please print)

Student's Name Last ______________ First ______________ Middle ______________

Student's Birth Date ______________ Age ______________ Gender *Male* *Female*

Parent/Guardian Name Last ______________ First ______________ Relationship ______________

Student's Address ______________ City ______________ Zip Code ______________

B. Vaccine Eligibility Screening (Please check appropriate box)

- ☐ **Medicaid** A child, 0 through 18 years of age, who has Medicaid as primary insurance.
- ☐ **American Indian/Alaskan Native** A child, 0 through 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance.
- ☐ **No Health Insurance** A child, 0 through 18 years of age, who does not have health insurance.
- ☐ **Insurance Does Not Cover Vaccines (Underinsured)** A child, 0 through 18 years of age, who has commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (these children are categorized as underinsured for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured).
- ☐ **Fully Insured** A child, 0 through 18 years of age, who has health insurance which provides coverage for vaccines. If primary insurance denies the claim and Medicaid is a secondary insurance, the healthcare provider will make the adjustment and bill Medicaid.

C. Vaccine Health Screening (Circle Yes or No)

Please answer all questions about the student who will be receiving the vaccine(s). Answers will determine whether the student can be vaccinated at this time.

Yes No 1. Does the student have any allergies to medication, foods, or any vaccines?
If yes, please explain ______________________________

Yes No 2. Has the student had a serious reaction to a vaccine in the past?

Yes No 3. Has the student had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?

Yes No 4. Has the student had a seizure, brain or other nervous system problem, including Guillain-Barré Syndrome?

Yes No 5. Does the student have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?

Yes No 6. Has the student taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?

Yes No 7. Has the student received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?

Yes No 8. Is the student pregnant or is there a chance she could become pregnant during the next month? *If yes, student should not receive MMR, HPV, or varicella vaccines.*

Yes No 9. Has the student received vaccinations in the past four (4) weeks?
If yes, please list vaccines ______________________________

D. Consent to Vaccinate

I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for the each vaccine my child will be receiving. I have had a chance to ask questions and fully understand the benefits and risks of each of the indicated vaccines and ask the following vaccines be given to my child on the scheduled school clinic date (check all that apply):

- ☐ Meningococcal ACWY (MCV4)
- ☐ Meningococcal Serogroup B (MenB)
- ☐ Polio
- ☐ Hepatitis A
- ☐ Tetanus, diphtheria, acellular pertussis (Tdap)
- ☐ Measles, mumps, rubella (MMR)
- ☐ Diphtheria, tetanus, acellular pertussis (DTaP)
- ☐ Varicella (Chickenpox)
- ☐ Hepatitis B
- ☐ HPV

Student Name: ______________________________ **DOB:** ________________

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I give permission to the Greene County Health Department, the Indiana State Department of Health, and/or their designees to vaccinate the student named on this form.

Signature of Parent/Guardian ____ Date ______________

E. To Be Completed by Person Administering Vaccine

Vaccine	Manufacturer/Lot Number/Expiration Date	Signature of Vaccinator	Site	Route	Date of VIS
MCV4			Left or Right Deltoid	IM	
Tdap			Left or Right Deltoid	IM	
Varicella			Left or Right Arm	SC	
MMR			Left or Right Arm	SC	
IPV			Left or Right Deltoid	IM	
Hep B			Left or Right Deltoid	IM	
Hep A			Left or Right Deltoid	IM	
DTaP			Left or Right Deltoid	IM	
HPV9			Left or Right Deltoid	IM	
MenB			Left or Right Deltoid	IM	

Entered into CHIRP by ________________________________ Date ________________

The HPV and MenB vaccines are not school requirements. However, it is a requirement of school-based clinics enrolled in the VFC program to offer the HPV and MenB vaccines to both boys and girls.

INSURANCE INFORMATION: (Please Print Clearly)

First Name: ________________________ Last Name: __________________ DOB: __________

Address: ____

City: ______________________ State: __________ Zip: ____________________

Phone: ____________________

Guardian Name: ____

Primary Insurance: _______________________________ Member ID: __________________

Group ID: ____________ Relationship to Insured: ____ Self ____ Spouse ____ Dependent

Insured First Name: _____________________ Insured Last Name: ______________________

Insured DOB: _____________________