Full School Name:

Morrow County Health District
School Based Immunization Clinic

Grade:

Teacher:

First Name: **Middle Initial:**

Last Name: **Gender:**

Address:

City: **State:** **Zip:**

Phone: **Home** **Cell** **Work** **Birthdate:** M M D D Y Y Y Y **Age:**

Race: **Email address**

☐ PATIENT **DOES** HAVE HEALTH INSURANCE (please fill out information below) ☐ PATIENT **DOES NOT** HAVE HEALTH INSURANCE

PRIMARY Insurance Company: **Member/Subscriber ID:**

Group#: **Claims Submission Address (see back of card)**

Primary Insured Name: **Relationship:**

Birthdate: **Social Security Number:**

Address of Primary Insured (if different from patient):

SECONDARY Insurance Company: Member/Subscriber ID:

Group#: Claims Submission Address (see back of card):

Secondary Insured Name: Relationship:

Birthdate: Social Security Number:

Address of Secondary Insured (if different from patient):

PLEASE SELECT WHICH VACCINE(S) you would like your child to receive (child must be at least 11 years old):

☐ Tdap (required for 7th grade) ☐ Meningococcal (required for 7th and 12th grade) ☐ Hepatitis A (Recommended) ☐ Human Papillomavirus (Recommended)

Please answer the following questions for your child:	YES	NO
1. Are you prone to fainting or light-headedness with shots?		
2. Do you have any allergies? If yes, please list:		
3. Have you ever had a serious reaction after receiving any vaccination? If yes, please describe:		
4. Do you have a neurological or brain disease? If yes, what:		
5. Have you ever had a paralyzing illness (Guillain-Barre Syndrome)?		
6. If female, are you pregnant?		

The Morrow County Health District may keep this record in your medical file. MCHD will record what vaccine was given, the date the vaccine was given, the name of the company that made the vaccine, the vaccine lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking recall and recording, unless I request otherwise. I have read or have had explained to me the information sheet about Hepatitis A, HPV, MCV4 and Tdap diseases listed above and the vaccines. I have had a chance to ask questions, and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine be given to the person named above for whom I am authorized to make this request. My medical information will not be shared without an authorization to release information. A copy of the Health Districts Notice of Privacy Practices (HIPAA) will be provided. I authorize my insurance company to assign the amount payable directly to MCHD. I understand that **I am financially responsible for all the charges that are not covered under my private insurance plan**. I acknowledge that any co-payment is due and payable on the date services are received.

Parent/Guardian Name (please print clearly): Parent/Guardian Date of Birth:

Parent/Guardian Signature: _____

Relationship to Patient: **Date:**

Nurses: _____NN _____IMPACT Admins: _____Ins. Check _____NN _____IMPACT

STOP — AREA BELOW FOR OFFICE USE ONLY

Adacel

LD IM / RD IM

LOT #:_____

EXP:_____

Vis Date: 02/24/2015

Menactra

LD IM / RD IM

LOT #:_____

EXP:_____

Vis Date: 03/31/2016

Gardisil 9

LD IM / RD IM

LOT #:_____

EXP:_____

Vis Date: 12/02/2016

Vaqta Ped/ Havrix Ped

LD IM / RD IM

LOT #:_____

EXP:_____

Vis Date: 07/20/2016

RN: _____

Date Given :_____

☐ Private : ☐ VFC: