

Consent for Meningitis Vaccination of Student

FOR ADMINISTRATIVE USE ONLY

Location: _____
Date: _____

PRIVATE _____ STATE _____
Cash _____ Check # _____

Nursing Signature: _____

MCV/MCVC Lot# _____ Location _____ Exp Date _____

PLEASE COMPLETE AND SIGN

Name of Student: _____ Student DOB: _____

Student Gender: Circle: M or F Student Race: _____

Student Address: _____ City: _____ Zip: _____

Parent Phone Number: Home: _____ Cell: _____

BILLING INFORMATION

Check Box:

Uninsured- Vaccination will be provided at no cost

Medicaid, Peachstate, Wellcare, Amerigroup- Vaccination will be provided at no cost

Insured –Vaccination will be billed to insurance company

CIRCLE: BCBS (all plans), CIGNA, United Healthcare, Tricare, Secure Health

ATTACH A COPY OF INSURANCE CARD TO CONSENT FORM PLEASE. If insurance information is not provided, vaccine cannot be given.

Please initial:

____ I do hereby give my consent for my child to receive the vaccine(s) indicated above. The vaccine will be administered by a licensed nurse. I understand that the vaccine my child will receive is recommended by the Center for Disease Control (CDC) for the prevention of the disease indicated. I have received and read the Vaccine Information Statement for the vaccine indicated vaccine and understand the risks and benefits of vaccination.

____ I acknowledge that I received a copy of the Notice of Privacy Practices for the North Central Health District (NCHD), which sets forth the ways in which my child's personal health information may be used or disclosed by the NCHD or the county health department, and outlines my rights with respect to such information.

____ I understand that the Houston County Health Department requires payment in full at the time of service if we are not filing one of the above insurance plans. Our office may verify benefits for the above insurance companies prior to providing services. Insurance filed by our facility is not a guarantee of payment by the insurance provider. It is the patient's responsibility to read and understand their insurance benefits..

Please circle:

My child has had a serious allergy to gentamicin, latex, gelatin, arginine, yeast, or any vaccine. YES NO

My child has had a serious reaction to a previous vaccine. YES NO

My child has had a fever of 101 degrees or more in the past 24 hours. YES NO

A "YES" answer to any of the following questions means that you must consult your doctor and the shot CANNOT be given in the offsite clinic. Please address any concerns not addressed above with the nurse PRIOR to vaccination

SIGNATURE: _____ DATE: _____