VACCINE REGISTRATION – SCHOOL-BASED CLINICS – REQUIRED SCHOOL VACCINES

What will your child's school grade be in Fall 2023? (circle answer) **7th grade** **12th grade**

PATIENT NAME: _____ **DATE OF BIRTH**_____**AGE**_____

ADDRESS: STREET_____ **CITY**_____ **ZIP CODE**_____

PHONE ( ) _____ **MALE or FEMALE (circle one)** **Approx. Weight** _____

IF PATIENT IS UNDER AGE 18:

Name of Parent of Legal Guardian: (please print) _____ **Relationship:** _____

Phone number parent/legal guardian can be reached DURING THE VACCINE CLINIC: _____

INSURANCE INFORMATION:

Does the Patient Have Insurance or a Medical Card? (circle answer) **YES NO**

If Yes: Insurance Company Name: _____ **ID or Policy #:** _____

Patient's SSN: _____

Consent for assignment of benefits: If your child has insurance, the Scioto County Health Department is authorized to bill your insurance company for the cost of the vaccine (if private insurance) and for an administration fee (if a Medicaid or private insurance) to help us cover the cost of our clinics. If you have private insurance and your insurance company does not pay the cost of the vaccine, you will be billed for the cost of the vaccine ($60 for a Tdap and $120 for a Meningitis vaccine). If your child has Medicaid, you will not be billed. **I consent for the Scioto County Health Department to bill my insurance company for the vaccine and administration fee.**

Signature of parent/legal guardian (or patient if 18 or over) : _____ **Date**_____

PLEASE CHECK ALL VACCINES YOU WANT YOUR CHILD TO HAVE:

Required for school:

_____ Tdap (7th grade)

_____ Meningococcal (7th AND 12th grade)

Recommended for Age:

_____ HPV (2 or 3 doses, depending on age)

_____ Hepatitis A (2 doses 6 months apart)

_____ Meningitis B (not contained in other Meningitis vaccine (2 doses 1 month apart)

WRITTEN REQUEST, CONSENT FOR VACCINE ADMINISTRATION, INFORMATION RELEASE, AND NOTICE OF PRIVACY PRACTICES:

The Scioto County Health Department's Notice of Privacy Practices is posted on the Scioto County Health Department's website http://www.sciotocountyhealth.com. The Vaccine Information Sheets (VIS) are available online at www.immunize.org as follows: Tdap https://www.immunize.org/vis/tdap.pdf, Meningococcal https://www.immunize.org/vis/meningococcal_acwy.pdf , Meningitis B https://www.immunize.org/vis/meningococcal_b.pdf ,Hepatitis A https://www.immunize.org/vis/hepatitis_a.pdf , HPV https://www.immunize.org/vis/hpv.pdf . If you are unable to access these documents online, would like us to provide you with a paper copy, or have questions about our privacy practices or the vaccine, please call 750-355-8358 (Nursing Division, option 2).

I hereby attest that I am the parent, legal custodian/guardian/medical POA of the above-named person who is a student at the _____ Local School District. I have read or had explained to me the Vaccine Information Statements about these vaccines as listed above, and the Scioto County Health Department's Notice of Privacy Practices. I understand the benefits and risks of the vaccine(s) and I have had a chance to ask questions about the vaccine(s) which were answered to my satisfaction. I hereby request and give consent to the Scioto County Health Department and its staff/employees/agents for the person named above to be vaccinated and give consent for the vaccine(s) checked above to be administered to said person for whom I am authorized to give this consent, even if I am not present when the vaccine(s) are administered. In consideration having the vaccine(s) administered to the person named above, I hereby release Scioto County and the Scioto County Board of Health, its officials, employees, and agents, together with all persons assisting with any phase of this vaccine program, from all liability and responsibility for any loss or injury related to the vaccine(s) being administered. I further agree to indemnify and hold harmless said parties from all claims hereafter made by me or on behalf of the person named above by any person or entity or their heirs, executors, or assigns. I also grant permission for the immunization record of the person named above to be released to providers, health departments, schools, the state immunization registry, and others as necessary for public health purposes.

Signature of parent/legal guardian (or patient if 18 or over): _____ **Date**_____

IMPORTANT: PLEASE ANSWER ALL THE SCREENING QUESTIONS ON THE FOLLOWING PAGE. *(rev. 2-13-2023)*

Patient Name: _____ **today's date**_____

Screening Checklist for Contraindications to Vaccines for Adults and Children

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Please answer the questions below about the person being vaccinated

			Don't
1. Are you sick today?	☐	☐	☐
2a. Do you smoke?	☐	☐	☐
2b. If yes, would you like help to quit smoking?	☐	☐	☐
3. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
4a. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4b. Have you ever had Guillain-Barre syndrome?	☐	☐	☐
5a. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
5b. Do you take a daily aspirin or are you on other blood thinners?	☐	☐	☐
6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
7. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
8a. (Adult patient): Have you had a seizure or a brain/other nervous system problem?	☐	☐	☐
8b. (If child): Has the child, a sibling, or a parent had a seizure; or has the child had a brain or other nervous system problem?	☐	☐	☐
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. (If child age 2 – 4 years): Has the child had wheezing in the past 12 months?	☐	☐	☐
12. (For infants): Have you ever been told your baby has had intussusception?	☐	☐	☐
13. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by:_____ Date:_____

Nurse reviewed by: _____ Date:_____