CLAY COUNTY
PUBLIC HEALTH CENTER

800 Haines Drive Liberty, MO 64068 **p.** 816-595-4355 clayhealth.com

Immunization Consent Form

Instructions: Complete both sides and return the completed form to your school nurse. Please include a photocopy of the front and back of your health insurance card if privately insured.

** Please Print **

A. **Demographics**

Student's Name: Phone:

Date of Birth: Marital Status:

Address: City/State/Zip

Race: Sex: Gender: Ethnicity: Language:

Parent/Guardian Name: Parent/Guardian Phone Number:

B. Insurance Coverage: (If private insurance, skip section B)

Please check the appropriate box. If you check one of the following statements, skip section C and go directly to section D.

☐ I currently do not have insurance

☐ My insurance does not cover vaccines

☐ I currently have Medicaid DCN # _____

C. Name of Primary Health Insurance:

Name of Employer (if policy provided as a benefit):

Name of Policy Holder:

Policy Holder Phone Number:

Policy Holder Address:

Policy Holder Date of Birth:

Policy or Member Number:

Group Number:

Customer Service or Provider Phone Number on back of the Insurance Card:

If Tricare Insured, Social Security Number or Benefits #:

D. AUTHORIZATION AND CONSENT:

I would like my child to receive: (MCV required for school attendance)

☐ MCV (Meningitis) ☐ HPV ☐ FLU ☐ MEN B ☐ All recommended vaccines

Personal Financial Responsibility: By signing this form, and in return for the services rendered by Clay County Public Health Center (CCPHC), I am personally responsible for all fees not paid by any third party on my behalf.

Assignment of Insurance Benefits: I hereby assign all my interest and rights to all insurance benefits otherwise payable to me from any policy to CCPHC. I agree that CCPHC may disclose any portion of my medical, financial, or personal information to any person or organization requiring such information as a condition of paying, receiving payment for, or justifying payment for my health care or the health care of one for whom I am responsible. I further authorize payment of all insurance benefits, otherwise payable to me, for all treatment provided directly to CCPHC.

My signature indicates that I have reviewed a copy of the Notice of Privacy Policy and have read the Vaccine Information Statement (VIS) for each vaccine that I am requesting be given to the person named on the form.

Signature of Patient, Parent, or Legal Guardian: _____

Print Name: Date:

Relationship to Student (self, parent, or guardian)

Please complete back of form

** For Office Use Only **

Is Insurance Active?

Trace Number:

STUDENT SCREENING FORM

Clinic Site _____

Please answer questions about the person receiving the vaccine(s) by circling yes or no questions 2-13

The following questions will help us determine which vaccines you may be given today. If you answer yes to a 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.

1	Are you sick today?	Yes/No
2	Do you have allergies to medications, food, a vaccine component, or latex?	Yes/No
3	Have you had a serious reaction to a vaccine in the past?	Yes/No
4	Do you have a health problem with lung, heart, kidney, or metabolic disease (i.e., diabetes), asthma, or a blood disorder? Are you on long term aspirin therapy?	Yes/No
5	Have you ever had a seizure, or had a brain or other nervous system problem?	Yes/No
6	Do you have or live with someone who has cancer, leukemia, HIV/AIDS, or immune system problems?	Yes/No
7	In the past 3 months, have you taken medications that affect the immune system such as prednosone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disase, or psoriasis; or had radiation treatments?	Yes/No
8	In the past year, have you received a blood transfusion or blood products, or have been given a medicine called immune (gamma) globulin or an antiviral drug?	Yes/No
9	Have you had an allergic reaction to latex, eggs, gelatin, or neomycin? (circle)	Yes/No
10	Have you received any vaccinations in the past 4 weeks?	Yes/No
11	Did you bring your immunization record with you?	Yes/No
	Additional Questions for Females Only:	
12	Are you nursing, pregnant, or is there a chance you could become pregnant during the next month? If pregnant, how many weeks? _____	Yes/No
13	Are you currently using a birth control method?	Yes/No

FORM COMPLETED BY: _____ DATE_____

(Patient/Parent/Guardian signature)

FORM REVIEWED BY: _____ DATE _____

(Nurse signature)

----------FOR CLINIC NURSE USE ONLY----------

Temperature if applicable _____

Circle Vaccine Source: VFC 317 County Purchase

VIS	Vaccine	Date	MFG	Lot #	Exp	Amt	Site	