Consent for Meningitis Vaccination of Student

FOR ADMINISTRATIVE USE ONLY

Location: ____ PRIVATE ______ STATE ______
Date: ____________________ 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 OR the TB skin test. The vaccine(s) and TB Skin test will be administered by a licensed nurse at my child's school. 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. The TB skin test is to evaluate for possible exposure to TB. I have received and read the Vaccine Information Statement for the vaccine indicated vaccine and understand the risks and benefits of vaccination. By signing below, I consent to my child receiving the vaccination and/or TB Skin test and attest that the information I have provided is true and accurate.
___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 mentioned insurance plans. Our office may verify benefits for the above insurance companies prior to providing services. However, we are unable to verify coverage during off-site campaigns. Denied claims, due to non coverage will be billed to the patient for payment by the patient. 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. TB Skin tests are not covered by insurance in most cases. I understand that I must pay for this service.
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 or has had a positive TB skin test in the past. **YES NO**

My child has had a MMR vaccine, Varicella vaccine, or a TB skin test within the past 30 days. **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:**_____________________________