

STUDENT TDAP/MENINGOCOCCAL CONSENT FORM 2015-2016

Student Information *(Print all information in black or blue ink)*

Patient/Student Name *(First, Middle, Last)*

School Name

Parent/Guardian Name *(if Patient/Student is less than 18 years)*

Student Date of Birth *(Month-Day-Year)*

Street Address

City

OH
State

Zip Code

()
Home Phone

()
Cell Phone

Student's Age

Student's Grade

Sex: Male Female Other: _____

Race and Ethnicity: Please check **all that apply** for your child:

American Indian/Alaskan Native White Native Hawaiian/Pacific Islander
 Black or African American Asian Other: _____

Hispanic/Latino:
(check one below)
 Yes No

Student's Main Language: English Spanish Somali Nepali Other: _____

Screening Information *(Please check "yes" or "no" for each question)*

	Yes	No
1. Is the child prone to fainting or light-headedness with shots or blood draws?		
2. Has the child ever had a severe (life-threatening) allergic reaction after receiving a tetanus, diphtheria or pertussis containing vaccine in the past?		
3. Has the child ever experienced a coma, decreased level of consciousness, or prolonged seizures within one week of receiving a pertussis-containing vaccine (DTaP, Tdap) that was not due to another cause?		
4. Has the child ever had a severe (life-threatening) allergic reaction to a previous dose of meningococcal (MCV4 or MPSV4) vaccine in the past?		
5. Does the child have a seizure disorder?		
6. Has the child had a seizure in the past 3 months?		
7. Does the child have a brain or other neurological disease?		
8. Has the child ever had Guillain-Barré syndrome?		
9. Females only: Is the student pregnant or is there a chance she could become pregnant during the next month?		
10. Staff use only: Is the child sick today?		

Consent By Guardian

I consent to let Columbus Public Health give **the following** vaccine(s) to my child: ***(please check each vaccine that you want given to your child)***

Tdap vaccine (required for 7th grade, child must be at least 11 years old)

Meningococcal vaccine (required for 7th grade and 12th grade, child must be at least 11 years old)

- OR -

NO, I do not want my child to receive the Tdap or Meningococcal vaccine at the school-based clinic ***(please sign this form on the reverse side and return signed form)***



Signature *(All forms must be signed)*

I have read or had explained to me the Tdap *Vaccine Information Statement* and/or the Meningococcal *Vaccine Information Statement* and I understand the risks and benefits. I give consent for the child named at the top of this form to get vaccinated with this vaccine according to ACIP guidelines.

I give permission for Columbus Public Health staff to treat and care for the needs of the above mentioned patient/student. I also understand that any care received outside Columbus Public Health (e.g., referred care) will not be paid for by Columbus Public Health. Administered immunizations will be entered into the statewide immunization information system (*Ohio ImpactSIS*). I authorize the release of medical information necessary to process this claim for billing. I agree to pay my co-pay and for any charges not covered by insurance or grants, unless I sign the hardship waiver below.

I understand that the Privacy Notice of Columbus Public Health is available on the internet at www.columbus.gov/HealthPrivacyPolicy . I can also have it mailed to me by calling 614-645-2738.

Parent/Legal Guardian Signature: _____ **Date:** ____/____/____

Relationship to Student: Mother Father Legal Guardian

- OR -

X _____ **X** _____ **X** _____ **X** _____
Student (Patient) Printed Name **Student (Patient) Signature (if 18 years or older)** **Date** **Phone**

**Any reference to 'my child' means 'myself' once a minor turns 18 years old*

Health Insurance

Please check which insurance carrier your child is covered by, or sign below if you don't think your child has insurance. The *Vaccines For Children (VFC) Program* provides free vaccines to children who are: Medicaid-eligible; without insurance; American Indian or Alaska Native; or underinsured. Medicaid and private insurance is billed when possible, but you will not be billed.

Medicaid Managed Care Plans *(check one below)*: Managed Care ID#: _____



Ohio Medicaid:  **MEDICAID # (12 digits):** _____

The student does not have health insurance *(must sign for hardship waiver)*

SIGN HERE: I am unable to pay for health services: **X** _____

Private Insurance (other than Medicaid):

Information from insurance card: Insurance company: _____

Subscriber ID or member #: _____ Group #: _____

Name of person under whom child is covered: _____ Birth date of insured adult: _____

Phone # on insurance card: _____

Claims address on insurance card: _____

OFFICE USE ONLY:	NextGen # _____	Tdap: R L Time: _____	Meningococcal: R L Time: _____
	VFC Private >18	Lot: _____	Lot: _____
			Sequence: 1 2
Comments:	Administered by: _____		
	Date: _____	NextGen documentation complete: _____	
SCHOOL USE ONLY: Room # _____			