Administration of Tdap, Meningitis, Meng. Serogp B or HPV Vaccine

STUDENT'S NAME (Last)	(First)	(M.I.)	STUDENT'S DOB	RACE:
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	STUDENT'S AGE	GENDER M / F
ADDRESS: COUNTY:			☐ Hispanic ☐ Non-Hispanic	PHYSICIAN: DENTIST:
CITY: TOWNSHIP	STATE:	ZIP:	Mother's Maiden Name	SCHOOL NAME:
PARENT / GUARDIAN DAYTIME PH ( )	STUDENT SOCIAL SECURITY	PARENT / GUARDIAN EMAIL		

1. Is your child currently well? If more than mildly ill on vaccination day, keep child home.	Y	N
2. Does your child have any allergies to any foods, medications, or vaccines? Please list:	Y	N
3. Has your child had problems after previous immunizations?	Y	N
4. Has your child had seizures, brain, or other nervous system problems?	Y	N
5. Has your child ever had Guillain-Barre Syndrome (a type of severe muscle weakness) within 6 weeks after receiving an immunization?	Y	N
6. Is your family experiencing a financial hardship?	Y	N
7. Is your child enrolled in Medicaid or a Medicaid HMO (Buckeye, CareSource,,Molina, Paramount, United Healthcare?)	Y	N
8. Is your child without health insurance coverage?	Y	N
9. Is your child a Native American or Alaskan Native?	Y	N
10. Does your child's health insurance cover vaccinations?	Y	N
11. Has the annual maximum amount of vaccine coverage for this child been met this year?	Y	N
12. Does your child's health insurance only pay for certain vaccines?	Y	N

- I have received a copy and have read or had read to me the information contained in the appropriate vaccine information sheet about the disease(s) and questions were answered to my satisfaction.
- I understand the benefits and risks of the vaccine(s) and ask that the vaccines(s) indicated on this sheet be given to me or to the person named above for whom I am authorized to make this request. I have been advised that a 15-minute waiting period after vaccination is recommended to observe for fainting episodes that can sometimes occur.
- I give permission for this record to be released to medical providers, health departments, schools, daycare centers, and the State of Ohio Impact Statewide Immunization Data System.

X_____ X_____

Parent / Guardian / Authorized Person Date

DIAGNOSIS CODE Z23

P	V		Date Administered	Injection Site (circle)	Mfg./ Lot Number Exp.Date:	Name and Title of Administrator	Date of VIS sheet
P	V	TDaP 90715	Date Administered	Rt. Deltoid Lt. Deltoid			VIS Date 02.24.15
P	V	Meningococcal 90734	Date Administered	Rt. Deltoid Lt. Deltoid			VIS Date 03.31.16
P	V	Meng Serogp B 90620	Date Administered	Rt. Deltoid Lt. Deltoid			VIS Date 08.09.16
P	V	HPV 90651	Date Administered	Rt. Deltoid Lt. Deltoid			VIS Date 12.02.16

Pvt & CareSource Insurance: First Dose 90471 90472 Additional Doses 90460 For Buckeye, Medicaid, Molina (How Many _____)

UHC Medicaid & Paramount (No Admin Code)

Amount Paid: _____ Receipt #: _____ Receipt Date: _____ Staff Initials:_____ No walkout statement / No Insurance

Cash Check # _____ Master Card Visa Discover 99883 _____ How Many?

Triage RN: _____ Clerical Support: _____ Billing: _____ 99884 _____ How Many?

PATIENT/PARENTAL CONSENT AND SIGNATURE PAGE

Releases and Permission to Provide Healthcare Services: By my signature below, I affirm that the information provided on the reverse side of this form is accurate and complete to the best of my knowledge. I give permission for my child/myself to receive examination, screening, laboratory tests which may include the collection of blood samples, immunizations, and other medical treatment as deemed necessary. I authorize this agency to release any personal and/or medical information required to process health insurance claims and to secure the payment of my child's/my health insurance benefits. I understand that all immunizations provided are documented in the Ohio State Immunization Registry. I further authorize payment of health insurance benefits, including but not limited to Medicaid and/or Medicare, directly to Medina County Health Department. I have reviewed the Medina County Health Department Notice of Privacy Practices (HIPAA) effective September 23, 2013, and have been given the opportunity to have my HIPAA-related questions answered. I understand that this agreement will remain in effect for the entire duration of time that Medina County Health Department provides medical care to my child/myself. I have read and fully understand all statements contained in this form.

Consent for assignment of benefits: I consent to make all payments for the services given today to the Medina County Health Department. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be stated to be my responsibility by the insurance carrier, as required by any contract with my insurance carrier and state regulation. I also understand that my contract with my insurance carrier may or may not cover some services. It is my responsibility to get information from my health insurance carrier about services that are covered. If I get care outside my health insurance plan, I am aware that I may be responsible for all charges that may be due. A returned check fee of $22.00 will be made to your client account for a check returned for insufficient funds, stopped payment of closed account.

X_____ X _____ _____

Signature of Patient/Parent/Guardian | Printed Name and Relationship to Patient | Date

_____ _____

Student's Name | Date of Birth

OR: I prefer to self-pay for all services received today at the Medina County Health Department Public Health Nursing Division. This decision is of my own free will and I am aware that I am waiving my right to have my insurance company billed for today's services. Furthermore I have been advised of the contractual service agreement between Medina County Health Department and my insurance company. I understand that the Medina County Health Department will not be obligated to provide a claim for reimbursement pertaining to this service.

I *do not* give permission for my insurance agency to be billed for services. I will self-pay for all services and fees.

_____ _____ _____

Signature of Patient/Parent/Guardian (Patient may sign if 18 years of age or older) | Printed Name and Relationship to Patient | Date

_____ _____

Signature of MCHD staff /witness to signature | Date

Please complete this information for the following insurance plans:

Aetna, Anthem/Blue Cross, Buckeye, CareSource, CareSource Marketplace, Cigna, Medicaid, , Medical Mutual, Molina Health Care, Paramount Advantage, United Health Care, United Health Care Community Plan, and some SummaCare commercial plans.

Primary Insurance Company: _____ ID Number: _____

Relationship to insured: ☐ Child ☐ Self ☐ Spouse ☐ Other Group Number: _____

Insurance Holder's Name: _____ DOB: _____ Sex: _____

Social Security Number: _____ Street: _____

If different than patient address Phone: _____ City, State. Zip: _____

Secondary Insurance Company: _____ ID Number: _____