Health Heroes Vaccination Clinic

Patient Consent Form - Meningococcal (MenACWY)

SCHOOL DISTRICT NAME: _____

Partners for Success and Innovation

PATIENT INFORMATION

First Name:	MI	Last Name:

Date of Birth:	Age:	Gender:	Name of School:	Grade:
M M / D D / Y Y Y Y		Male / Female		

Patient Race:	White	African American	Amer. Indian/ Native American	Hispanic	Alaskan Native	Asian	Other:

Address:	City:

Cell/Emergency Contact Phone #: ( ) -

State:	Zip Code:

CONTACT INFORMATION & PARENT/GUARDIAN INFORMATION

First Name:	Last Name:	Relationship:

REQUIRED INSURANCE INFORMATION (*MUST* check an appropriate box)

NON-PRIVATE		OTHER: (please specify insurance carrier name here) *If HMO plan: (i.e. Buckeye, BCN, CareSource, Paramount Advantage, etc) NOTE: info may be found on the reverse side of the insurance card	PRIVATE INSURANCE						
NO INSURANCE	Medicaid (If HMO, name in Other)		Aetna	BCBS	CIGNA	Humana	Medical Mutual	Tri-Care	UHC

Cardholder's First Name:	Cardholder's Last Name:	Cardholder's Date of Birth:
		M M / D D / Y Y

Contract ID:(please include prefix, if any)	Group #:

VACCINATION & HEALTH-RELATED QUESTIONS

1	Is this the patient sick today?	YES	NO
2	Does this patient have allergies to medications, food, or any vaccine component, or latex? If yes, list here:	YES	NO
3	Has this patient ever had a serious reaction to a vaccine in the past? If yes, describe here:	YES	NO
4	Has this patient or immediate family member had Seizures or other brain/nervous system problems? If yes, please describe:	YES	NO
5	Does this patient have cancer, leukemia, HIV/AIDS, or any other immune system problems? If yes, describe here:	YES	NO
6	In the past 1-3 months, has this patient taken any medications that affect the immune system such as Cortisone, Prednisone, other steroids, or anti-cancer drugs; or medications for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatment? If yes, list medication & date of last treatment here:	YES	NO
7	Has this patient received a transfusion of blood or blood products, or been given immune (gamma) goblin or an anti-viral drug in the past year? If yes, please describe:	YES	NO
8	Is this patient pregnant or could become pregnant in the next month?	YES	NO
9	Has this patient received any other vaccinations within the last 4 weeks? If yes, please name the specific vaccination(s)?	YES	NO

I am aware that the receiver of this vaccine is currently not pregnant and should not become pregnant within four weeks of receiving this vaccine. I have read the information about the vaccine and special precautions on the Vaccine Information Sheet attached to this consent form. I am aware that I can locate the most current Vaccine Information Statement and other information on www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the patient above, of whom I am the parent or legal guardian and acknowledge no guarantees have been given made concerning the vaccines success. I hereby release the School District, Health Heroes, Inc., affiliated schools of nursing, and their directors or employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date.

Authorized Parent or Guardian Signature **Date**

For Administrative Use Only:

Clinic Location:		Date:	/ /
Vaccine Lot:		Exp. Date:	/ /
Site Admin:	Left Arm / Right Arm	RPh/RN:	
CDC VIS:	MenACWY 03-31-2016	Dosage:	0.5 mL