Meningococcal & Meningococcal B Immunization Consent Form

Patient Last Name _____ First Name_____

Date of Birth _____ Age _____ Male Female

Street Address_____

City _____ Zip _____

Phone_____

• I consent to my child receiving the Meningococcal ACWY vaccine which ***IS REQUIRED*** for entry into senior year of high school.	Yes	No
• I consent to my child receiving the Meningococcal B vaccine which is ***NOT REQUIRED*** but is highly recommended, it is a series of 2 vaccines separated by 1 month.	Yes	No
• Has your child ever had a reaction to a vaccine in the past? If YES please explain:_____	Yes	No
• Does your child have a history of seizures?	Yes	No
• Does your child have a weak or compromised immune system?	Yes	No

I consent and authorize my child to receive immunization(s) from Adams County Health Department without my physical presence. I am a legal parent/guardian to the above named student. I understand that the Adams County Health Department maintains the right to decline any immunization to my child if he/she is uncooperative and presents a risk for unintentional needle-stick to staff or himself/herself. I have had a chance to read information, including benefits and risks, regarding the immunization(s) offered and any questions have been answered. I authorize the above named child's immunization record to be released for public health and state law purposes to include Illinois Department of Public Health, school, and physician.

Parent/Guardian Signature_____ Date _____

INSURANCE INFORMATION ***(Copy of insurance ID Card will be required in order to submit insurance claim)***

Primary Insured/Subscriber Name_____

Subscriber Date of Birth_____

Subscriber/Member ID # _____

Group Name/# _____

Aetna	**Coventry**	**HFN**	**Healthscope**	**United Healthcare**
BlueCross	**Health Alliance**	**Humana**	**Molina**	**Illinois Medicaid**
Cigna	**Healthlink**	**Meridian**	**Mutual of Omaha**	

This section for office use ONLY

VACCINE	LOT #	SITE	Nurse
Meningitis			
Meningitis B			

Please complete back page

Screening Questions

1. Is the person to be immunized ill with something more than a cold, have a temperature of 102 or higher, or taking any medications? Yes No

2. Has the person received an immunization within the last 4 weeks? Yes No

3. Has the person had a reaction of high fever *(104 or greater)*, persistent screaming *(3 hrs. or longer),* sudden muscle weakness or other negative reactions following an immunization? Yes No

4. Does the person have a history of seizures? Yes No

5. Has the person received immune globulin or long term/high dose steroids in the past 3 months or received a blood or plasma transfusion in the last 11 months? Yes No

6. Is the person allergic to any foods, medicine, vaccines or latex? Yes No

7. *For females age 9 or over:* Is the person pregnant now or planning pregnancy in the next 3 months? Yes No

VFC Eligibility and Billing VFC Costs. I understand that the Vaccines for Children program (VFC) is a federally funded program with specific eligibility requirements. To the best of my knowledge, I have honestly answered all screening questions which determine my eligibility for the VFC program.

PAYMENT AGREEMENT AND ASSIGNMENT OF BENEFITS. Unless prohibited by an agreement between my payer source and Facility or by State or Federal law, I promise to pay all amounts due to Facility and Independent Contractors, including co-payments, deductibles or other charges, for medical services I received that are not covered or paid by insurance or other third party payers. I understand that the Independent Practitioners will bill separately for Facility. I authorize Facility to file any claims for payment and assign all my rights and benefits to Facility and Independent Practitioners as appropriate. I also agree, subject to State or Federal law, to pay all costs, attorney fees, expenses and interest if Facility has to seek collection action due to my failure to pay. If I am a Medicare beneficiary, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I understand that Facility is not liable for failure to meet any pre-certification required by my insurance carrier. I agree to pay for all services if pre-certification is denied by my insurer. It is my responsibility to Notify Facility of any changes in payer source.

Parent/Guardian Initials

Please call Adams County Health Department if you have any questions regarding this for or any vaccines.

217-222-8440