

SPECIAL EVENT IMMUNIZATION CONSENT FORM

Student's Name Last: _____ First: _____ Middle: _____

Date of Birth: _____ Age: _____ Gender: M or F

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Message: _____

Parent/Legal Guardian's Name: _____ Mother's Maiden Name _____

School Name: _____ Grade _____

Ethnicity Hispanic / Not Hispanic / Unknown **Race** White / American Indian / Black / Alaskan Native / Asian / Hawaiian—Pac Islander / Other

Circle all that apply *Ages 0-18 yrs only*

Medicaid / No Insurance / Insurance / American Indian / Alaskan Native

Medicaid Information

Name (as printed on card): _____ Medicaid# _____

Primary Insurance

Patient's relationship to insured: Self Spouse Child

Insurance Company: _____ Name of Primary Insured: _____

Primary Insured's Date of Birth: _____ Insured Phone: _____

ID#: _____ Group #: _____

Insured's address if different from above: _____

PLEASE READ AND INITIAL:

_____ Central District Health Department will bill your health insurance or Medicaid.

_____ IF YOU DO NOT have insurance you will be billed directly for the administration fee(s).

_____ I need financial assistance. My household size _____ My monthly Income _____

_____ I acknowledge that I was given a copy, and I have read the Central District Health Department Notice of Privacy Practices and Financial Policy (see attached)

For billing questions please call our Finance Department at 327-8594.

FOR OFFICE USE ONLY

Payment Category:

Staff initials: _____

Insurance

Medicaid

Other

PLEASE COMPLETE OTHER SIDE.
Child will not be vaccinated, if back side is not completed

The following questions will help us determine which vaccines you may be given today. Please circle YES or NO

Is the patient sick today?	YES	NO
Does the patient have allergies to medications, food, or any vaccine? (For example: eggs) Please list: _____	YES	NO
Has the patient ever had a serious reaction after receiving a vaccine? (Routine or Flu vaccines)	YES	NO
Has the patient ever had Guillain-Barre Syndrome (a type of temporary, severe muscle weakness), seizures or neurological disorders?	YES	NO
Does the patient have cancer, leukemia, HIV/AIDS, immune system problems, or have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	YES	NO
Does the patient take cortisone, prednisone, other steroids, or anti-cancer drugs, or has the patient had x-ray treatments? Long term aspirin therapy? Daily aspirin dose _____.	YES	NO
During the past year , has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? If yes, when? month _____ day _____	YES	NO
Has the patient received a MMR, Varicella, Rotavirus, or FluMist vaccine in the past four weeks ? If yes, when: month _____ day _____	YES	NO
Does the patient have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	YES	NO
Has the patient had chickenpox? If yes, when? _____	YES	NO
For females: Are you pregnant or is there a chance you could become pregnant during the next month?	YES	NO

ALL CLIENTS: PLEASE READ THE FOLLOWING, INITIAL, SIGN AND DATE

_____ Participation in and withdrawal from the Immunization Registry (IRIS) is voluntary. Call Idaho Immunization Program at 208.334.5931 to opt-out or withdraw. If you do not opt-out of IRIS in writing, your child's immunization records will be stored in the registry.

_____ I GIVE CONSENT to the Central District Health Department and its staff for my child named on the front of this form to be vaccinated for:

_____ Tdap Vaccine _____ Meningococcal Vaccine _____ Hepatitis A Vaccine _____ Varicella Vaccine

If this consent form is not signed, dated, and returned, then your child will not be vaccinated

Client/Guardian Signature: _____ **Relationship to Child:** _____ **Date:** _____

(FOR NURSES USE ONLY)

(FOR NURSES USE ONLY)

(FOR NURSES USE ONLY)

(FOR NURSES USE ONLY)

Nurse signature: _____

Date: _____