JEFFERSON COUNTY HEALTH DEPARTMENT

7th Grade Immunization Consent Form

Patient Information			
Last Name:	**First Name:**		**Middle Initial:**
Mother's Maiden Name:			
Mailing Address:			
City:	**State:**	**Zip Code:**	
Home Phone:	**Cell Phone:**	**Work Phone:**	
Primary Care Physician or Pediatrician:			
Date of Birth:	**Sex: Male ⬭ Female ⬭**		

Responsible Party – If patient is a minor please list the parent or legal guardian		
Last Name:	**First Name:**	**Middle Initial:**
Relationship to Patient:		
Address (if different from above):		
City:	**State:**	**Zip Code:**
Date of Birth:	**Phone Number:**	

In Case of Emergency – If different from responsible party
Emergency Contact Name:
Emergency Contact Number:
Relationship to Patient:

Primary Medical Insurance		
Insurance Company Name:		
Insurance Medical Claims Address:		
City:	**State:**	**Zip Code:**
Provider's Phone Number:		
Policy Holder Name:		
Policy Holder Date of Birth:	**Relationship:**	
Policy Identification Number:		
Group Number:	**Plan Number:**	

The JCHD Notice of Privacy Practices provides information about how we may use and disclose your protected information. The Notice of Privacy Practices is subject to change. A copy of our notice is available upon request. By signing this form, you acknowledge that the JCHD Notice of Privacy Practices was made available to you. You must be 18 years of age to sign this form. If under the age of 18, a parent or guardian's signature is required.

I have read or had explained to me the Vaccine Information Statement for the vaccine I will receive and I understand the risks and benefits. Vaccine Information Statements (VIS Forms) have been made available to me and I understand the information about the vaccine(s).

Jefferson County Health Department can bill the insurance listed for the immunizations. I request that payment of authorized third party benefits be made to Jefferson County Health Department for services furnished by the department. ***Submission of insurance information does not guarantee coverage. I understand that if the insurance company does not cover the vaccine(s), I will be responsible for payment.***

If your child is UNINSURED, contact the Jefferson County Health Department for information on the Vaccine for Children program at 304-728-8416.

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

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Please answer the following questions:	
Does the child have allergies to medications, food or any vaccine?	Yes ☐ No ☐ Unsure ☐
If yes, please list:	
Has the child ever had a serious reaction to a specific vaccine?	Yes ☐ No ☐ Unsure ☐
If yes, please list:	
Has the child ever had Guillain-Barre Syndrome within 6 weeks of receiving any tetanus containing vaccination?	Yes ☐ No ☐ Unsure ☐

☐ I ***GIVE PERMISSION*** for the Jefferson County Health Department staff to administer the vaccine(s) indicated below to my child named on the first page of this form.

Parent/Guardian Signature: _____

Please mark the box of the vaccines that you wish for your child to receive:

☐ **Tetanus, Diphtheria and Pertussis (Tdap) (Required by the State)** Private____ VFC____ Lot #:_____ Nurse Initials:_____ Date:_____	☐ **Human Papilloma Virus (HPV9) (Recommended by CDC)** Private____ VFC____ Lot #:_____ Nurse Initials:_____ Date:_____	☐ **Hepatitis A (Recommended by CDC)** Private____ VFC____ Lot #:_____ Nurse Initials:_____ Date:_____
☐ **Meningococcal (MCV4) (Required by the State)** Private____ VFC____ Lot #:_____ Nurse Initials:_____ Date:_____		

Signature of Nurse: _____

*The HPV9 vaccination is a 2-dose series for children if started before the age of 15. The second dose should be given six months after the first dose. If the child is the age of 15 or older at the time of the fist dose a 3-dose series is required.

*The Hepatitis A vaccination is a 2-dose series. The second dose should be given six months after the first dose.