HAMPSHIRE COUNTY HEALTH DEPARTMENT
12th 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 ⬭**		**Marital Status: S M D W**		

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:**	
Social Security Number:		

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

The HCHD 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 they HCHD 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 am to receive and I understand the risk and benefits. Vaccine Information Statements (VIS Forms) have been made available to me and I understand the information about the vaccine(s).

Hampshire County Health Department can bill the insurance listed for the immunizations. I request that payment of authorized third party benefits be made to Hampshire 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 my child is UNINSURED, I agree to pay $19.85 per immunization on the day it is given by cash or check made payable to Hampshire County Health Department.

I ***GIVE PERMISSION*** for the Hampshire County Health Department staff to administer the required/recommended vaccine(s) by the State Law at the School Immunization Clinic. ***Please mark the box of the vaccines that you wish for your child to receive on the back side of this form:***

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

Please turn this form over, additional information on the back

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Please answer the following questions:

Does this child have allergies to medications, food or any vaccine? Yes ☐ No ☐ Unsure ☐

If yes, please list:

Has this child ever had a serious reaction to a specific vaccine? Yes ☐ No ☐ Unsure ☐

If yes, please list:

Has this child ever had Guillan-Barre Syndrome (a type of temporary sever muscle weakness) within 6 weeks of receiving any tetanus containing vaccination? Yes ☐ No ☐ Unsure ☐

If your child has had these immunizations, please list the dates:

Tdap:_____ Hep A 1:_____ Hep A 2:_____

MCV4:_____ MenB:_____

HPV Dose 1:_____ HPV Dose 2:_____ HPV Dose 3:_____

☐ **Tdap (Required by the State)**

Private____ VFC____
Lot #:_____
Nurse Initial:_____
Date:_____

☐ **Meningococcal (MCV4) (Required by the State)**

Private____ VFC____
Lot #:_____
Nurse Initial:_____
Date:_____

The Hepatitis A vaccination and the Men B vaccination are a 2 dose series. The Hampshire County Health Department will return to your child's school to administer the required doses. After the first dose, the second will administered in five months. **Please initial for dose #2 in each box.**

☐ **Hep A #1 (Recommended by CDC)**

Private____ VFC____
Lot #:_____
Nurse Initial:_____
Date:_____

☐ **Hep A #2 (Recommended by CDC)**

Private____ VFC____
Lot #:_____
Nurse Initial:_____
Date:_____

Parent Initial:_____

☐ **MenB – Age 16+ (Recommended by CDC)**

Private____ VFC____
Lot #:_____
Nurse Initial:_____
Date:_____

☐ **MenB – Age 16+ (Recommended by CDC)**

Private____ VFC____
Lot #:_____
Nurse Initial:_____
Date:_____

Parent Initial:_____

The HPV9 vaccination is a 3-dose series. The Hampshire County Health Department will return to your child's school to administer the required doses. After the first dose, the second dose will be administered one month after and the third dose will be administered five months after. **Please initial for dose #2 and #3 in the box.**

☐ **HPV9 #1 (Recommended by CDC)**

Private____ VFC____
Lot #:_____
Nurse Initial:_____
Date:_____

☐ **HPV9 #2 (Recommended by CDC)**

Private____ VFC____
Lot #:_____
Nurse Initial:_____
Date:_____

Parent Initial:_____

☐ **HPV9 #3 (Recommended by CDC)**

Private____ VFC____
Lot #:_____
Nurse Initial:_____
Date:_____

Parent Initial:_____