12TH GRADE

2020 VACCINE SCHOOL-BASED CLINIC CONSENT FORM

ALL QUESTIONS MUST BE ANSWERED. IF YOU DO NOT COMPLETE THIS FORM & RETURN IT TO SCHOOL, YOUR CHILD WILL NOT BE VACCINATED! **FORMS NEED TO BE RETURNED NO LATER THEN JULY 15TH**

Student's Name: (Last)_____ **(First)**_____ **(M.I.)**_____

Date of Birth:_____ **Gender**: M / F **Phone Number:**_____

Race:_____ **Ethnicity**: Not-Hispanic / Hispanic_____

Street Address:_____

City:_____ **State:**_____ **Zip Code:**_____

INSURANCE TYPE: (CIRCLE ONE):

MEDICAID **NONE** **PRIVATE:** INSURANCE COMPANY: _____

MEMBER ID: _____

GROUP NUMBER: _____

***If you have insurance that covers vaccines, please submit your insurance card with this form. Whether your insurance will pay for the vaccine or not, your child will still be immunized by turning in this consent.**

*This/These Vaccines are (circle one) : **Covered** **Not Covered** **Coverage Unknown**

Please Circle the Vaccines you want your child to receive. (If this form was signed and returned with no selection made, the required vaccine will be given):

MENACTRA (REQUIRED) **MEN B** (RECOMMENED) **HEP A** (RECOMMENDED) **HPV (**RECOMMENDED)

SIGN BELOW: VACCINATION WILL NOT BE GIVEN WITHOUT PARENT/LEGAL GUARDIAN SIGNATURE:

I GIVE CONSENT to the Ste. Genevieve County Health Department and its staff for my child named on this form to be vaccinated with the vaccines I circled above. I understand the Vaccine Information Statement for these vaccines can be found at https://www.cdc.gov/vaccines/hcp/vis/ ,or picked up at the Health Department. **I GIVE CONSENT** for Ste. Genevieve Health Department to bill my insurance for the vaccine and/or administration fee.

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

VACCINATION RECORD: FOR ADMINISTRATIVE USE ONLY:

Vaccine	Date Administered	Route	VIS	Vaccine Manufacturer	Lot Number	Name of Administrator
		RD LD				
		RD LD				
		RD LD				
		RD LD				