Winona Health

School Immunization Clinic Parental Consent Form

School Name _____

In order for your child to obtain the adolescent vaccinations during this school-based clinic, you must
1. Complete both sides of this form, and 2. Sign & Date this form.
Please return this form to your school's main office or health office.

A. INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT)
Student's Name Last: _____ First: _____M.I.: _____
Student's Birth Date: _____Age: _____ Gender at Birth: □ Male □ Female
Race: □ White □ Black or African American □ American Indian or Alaska Native □ Asian □ Other: _____
Ethnic Group: □ Not Hispanic or Latino □ Hispanic or Latino □ Multiple groups □ Refuse to Answer
Student's Address: _____ City: _____ Zip Code: _____

Parent/Guardian Name Last: _____ First: _____ Relationship _____
Parent/Guardian Phone Number: _____ Email Address: _____
Parent's Address if different from student's: □ N/A □_____

B. INSURANCE INFORMATION (PLEASE CHECK APPROPRIATE BOX)

- □ **Medicaid/Medical Assistance** A child who has Medicaid as primary insurance.
- □ **American Indian/Alaskan Native** A child who identifies as an American Indian or Alaskan Native, regardless of insurance.
- □ **No Health Insurance** A child who does not have health insurance.
- □ **Insurance Does Not Cover Vaccines (Underinsured)** A child who has commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (these children are categorized as underinsured for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured).
- □ **Fully Insured** A child who has health insurance which provides coverage for vaccines. If primary insurance denies the claim and Medicaid is a secondary insurance, the healthcare provider will make the adjustment and bill Medicaid.

Insurance Name: _____Group ID #: _____ Subscriber #: _____
Name of Party Responsible for Billing (Last, First, MI): _____
Relationship to Patient: _____ Phone Number: _____
Responsible Party Address: _____City: _____State: ____Zip Code: _____

Complete both sides of this form.

C. VACCINE HEALTH SCREENING (CIRCLE YES OR NO) Please answer all questions about the student who will be receiving the vaccine(s). Answers will determine whether the student can be vaccinated at this time.

Yes No	1. Does the student have any allergies to medication, foods, or any vaccines? If yes, please explain: _____
Yes No	2. Has the student had a serious reaction to a vaccine in the past?
Yes No	3. Has the student had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?
Yes No	4. Has the student had a seizure, brain or other nervous system problem, including Guillain-Barré Syndrome?
Yes No	5. Does the student have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?
Yes No	6. Has the student taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?
Yes No	7. Has the student received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?
Yes No	8. Is the student pregnant or is there a chance she could become pregnant during the next month? If yes, student should not receive MMR, HPV, varicella, polio, or MenB vaccines
Yes No	9. Has the student received vaccinations in the past four (4) weeks? If yes, please list vaccines: _____
Yes No	10. Is the student taking aspirin?

D. CONSENT TO VACCINATE I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for each vaccine my child will be receiving. I have had a chance to ask questions and fully understand the benefits and risks of each of the indicated vaccines and ask the following vaccines be given to my child on the scheduled school clinic date (check all that apply):

- ☐ Meningococcal (Menveo)
- ☐ Tetanus, diphtheria, pertussis (Tdap)
- ☐ Human papillomavirus (HPV/Gardasil)
- ☐ Meningococcal B (MenB)
- ☐ Hepatitis B
- ☐ Measles, mumps, and rubella (MMR)
- ☐ Varicella
- ☐ Polio

I give permission to Winona Health to vaccinate the student named on this form.

Signature of Parent/Guardian _____ Date _____

Please return this form to your school's main office or health office.