Beaverhead County Public Health
41 Barrett Street
Dillon, Montana 59725-4000
Phone: (406)683-4771
Fax: (406)683-3188

imMTrax Consent Form for Children

PRINT Child's Name: _____

Sex: M___ F___ Date of Birth: _____/_____/_____

I authorize Beaverhead County Public Health to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Parent/Guardian Signature: _____

Date: _____/_____/_____

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September 27, 2023

TO: Parents
From: Beaverhead County Public Health
Re: School Immunization Clinic

Beaverhead County Public Health will be offering adolescent and influenza vaccine at Beaverhead County High School on October 11th. In order for Public Health to administer vaccine, **this letter, fee sheet, and insurance information** (and money if applicable) **must be** *-no exceptions-* with the student before vaccines are administered. Vaccine will not be given to any student without the completed paperwork and payment method. Complete and sign the front page of the fee sheet.

If you are unsure if your child has already received these vaccines, please call your healthcare provider or the public health department at 683-4771.

Vaccines Requested:
Please check the box(s) next to the vaccine you are requesting your child to receive.

- ☐ Meningococcal: Need 2 if first was given before age 16.
- ☐ Meningitis B: Age 16 and older. Series of 2 shots.
- ☐ Influenza: Injection only
- ☐ HPV: Series of either 2 or 3 shots. Depends on what age the first was given.
- ☐ Hep A: Series of 2 shots.

Insurance:
If your insurance covers vaccines, **STAPLE A COPY OF YOUR CARD (COPY BOTH SIDES) TO THE FEE SHEET** so we can bill your insurance. You must bring insurance information. You will be billed for the amount not paid by insurance.

Vaccine for Children:
☐ Healthy Montana Kids **Plus** (Only HMK+ is considered Medicaid)

If your child falls within the following criteria for the "Vaccine For Children" (VFC) program, we can provide vaccine to your child for $21.00 ***per*** vaccine. Please check the appropriate box(s). You must bring the money with the paperwork.

- ☐ I have no insurance
- ☐ I have insurance but it doesn't cover vaccine
- ☐ I am a Native American
- ☐ I am Alaskan Native

Private Pay:
If you choose not to bill your insurance or do not fall within the VFC program criteria, then the cost of the vaccine is as follows. You must bring the money with the paperwork.

1.	Meningococcal	$406.00
2.	Meningitis B	$556.00
3.	HPV	$541.00
4.	Hep A	$ 135.00
5.	Influenza	$ 91.00

It is important that you read the VIS (Vaccine Information Statement) found at
http://www.cdc.gov/vaccines/pubs/vis/default.htm
BEFORE your child receives any vaccine.
If you would like a hard copy, please stop by the public health department.

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Tax ID #: 81-600-1331

PRIVATE/COUNTY	VFC/STATE	VFA/STATE

FEE SHEET

PLEASE PRINT

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

(*Please circle*) **Gender:** *Male Female* **Race:** *White Black Am Indian Asian Pacific Islander Other* **Hispanic:** *Yes No*

INSURANCE INFORMATION:

ADULTS (19 yrs. and older)
- □ *NO Insurance*
- □ *Insurance DOES NOT cover immunizations*
- □ *Private Insurance/Medicaid/Medicare*

CHILDREN (0 through 18yrs.)
- □ *NO Insurance*
- □ *Insurance DOES NOT cover immunizations*
- □ *Private Insurance*
- □ *Medicaid (Healthy Kids Montana Plus)*
- □ *Native American*
- □ *Alaska Native*

SCREENING QUESTIONS: Check all that apply.

- □ *Pregnant Woman*
- □ *Infant or toddler 6-35 months old*
- □ *Household contact of infant <6 months old*
- □ *Person aged 3-64 years old who is at higher risk for for influenza-related complications*
- □ *Person aged 3-64 years old NOT at higher risk for influenza-related complications*
- □ *Adults 65+ years old*

AUTHORIZATION

1. I give consent for Beaverhead County Public Health to administer the requested immunizations.
2. I have been given the Vaccine Information Statement/Emergency Use Authorization Fact sheet and my questions have been answered to my satisfaction.
3. I authorize Beaverhead County Public Health to collect and enter mine or my child's immunization records into the State Immunization Registry.
   - This Registry is a confidential computer system that contains immunization records.
   - I understand that the information in the registry may be released to a public health agency, my healthcare provider, child care facilities, and schools in which my child is enrolled to comply with state immunization requirements.
   - I understand that I may revoke this authorization and have my record removed at any time. **PLEASE** sign here if you revoke this authorization: _____
4. I authorize Beaverhead County Public Health to bill my insurance and release information required to process this claim.
   - I assign my insurance benefits to be paid directly to Beaverhead County Public Health.
   - I agree that I am responsible for payment of non-covered services or for the unpaid balance of this bill.

Signature of patient OR parent/guarantor: _____

Printed name of parent/guarantor: _____