School Vaccinations - Consent Form
Parent – complete ALL highlighted sections

Jersey County Health Department
1307 State Hwy 109, Jerseyville, IL 62052

Demographics

Name, Last: ____________________First: ____________________ M.I.: ___ Date of Birth: ___/___/___ Age: _____

Address: ____ County: ____________________________

City: ______________________ State: _______ Zip: _________ Phone: ________________________________

Parent/ Guardian: _____________________________________ Physician: ____________________________

Payment Information - ***you must complete this entire section for the vaccine to be given!***

☐ Medicaid → MCO (circle one) BCCHP ABH Meridian Molina Youthcare Other: ___________

☐ Uninsured *(VFC eligible)* ☐ American Indian or Alaskan Native *(VFC eligible)*

☐ Private Insurance: Aetna BC/BS Cigna Coventry Health Alliance Healthlink Humana United Healthcare

Policy Holder:____________________ Member ID#:____________________ Group #: (if applicable) ________________

Does Your Insurance Pay for Vaccines? YES NO *(Yes = Insured = private pay)*

If YES, does JCHD have an agreement with my child's insurance to provide vaccinations? YES NO

If NO, I have included proof that vaccines are not covered by my child's insurance? YES NO

Put an "x" in the box below to indicate that you have the HIPAA information.

☐ **HIPAA** – I understand a *Notice of Privacy Practices* is available at my request. Under the Healthcare Insurance Portability and Accountability Act, I authorize to disclose my child's Immunization Record to his/her physician and/ or school. I also authorize the following person(s) to have access to my child's records:
(*It's OK if you don't write anyone's name)* ____

Screening Checklist for Contraindications to Vaccines

These questions help us determine which vaccines may be given today. If you answer "yes" to any question, it does not necessarily mean your teen should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask clinic staff to explain it.

Questions for All	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medicine, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?	☐	☐	☐
5. Is the child/ teen pregnant?	☐	☐	☐
6. Has the child ever felt dizzy or faint before, during or after a shot?	☐	☐	☐
7. Is the child anxious about getting a shot today?	☐	☐	☐

Additional Questions for Kindergarten	yes	no	don't know
1. Does the child have a blood disorder, no spleen, or are they taking regular aspirin or salicylate medication?	☐	☐	☐
2. Does the child have an immune-system problem (i.e. cancer, leukemia, HIV/AIDS), or does the child's parent or sibling have an immune system problem?	☐	☐	☐
3. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, anticancer drugs, or drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
4. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐

"I have completed this form to the best of my knowledge. I have been given, read and understand the possible side effects described in the Vaccine Information Statement (VIS) that could be caused by the vaccine(s). I consent for my child to receive vaccinations as indicated. I authorize JCHD to release service-related information about my child to third party payors and to bill for services rendered as appropriate. I request my payor to pay JCHD directly for services rendered. I agree to pay JCHD for any services not covered or paid by my insurance, and I understand JCHD may bill me for this amount."

Signature: ____ Date: ____________________
(parent/ legal guardian must sign unless 18y or older)