Franklin County Health Department
Consent Form

Today's Date: _____ School Name: _____

Student's Name: _____ Age: _____
First MI Last

Date of Birth: _____ Gender: _____ Race: _____ Ethnicity: _____

Parent/Guardian: _____
First MI Last

Address: _____ Phone Number: _____
Street City/State Zip

Insurance Carrier: _____ Patient's Medicaid # (if applicable): _____

Policy Holder Name: _____ Date of Birth: _____

Member ID# _____ Group ID# _____

Emergency Contact Person: _____ Contact Number: _____

	Yes	No	Do not know
Is the child sick today? (We will ask child the day of the clinic.)	☐	☐	☐
Does the child have allergies to medication, eggs, latex, or any vaccine?	☐	☐	☐
Has the child ever had a serious reaction after receiving a vaccination?	☐	☐	☐
Has the child had a seizure, brain, or neurological problem?	☐	☐	☐
Does the child have cancer, leukemia, AIDS, or any other immune disorder?	☐	☐	☐
Has the child received any vaccinations in the past 4 weeks?	☐	☐	☐
Has the child taken steroids or anti-cancer medication?	☐	☐	☐

Does the patient have any other allergies? Yes ☐ No ☐ If Yes, please list: _____

I understand I will be responsible for payment for the agreed upon services, these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. If consenting for another; I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

I give my consent to the Franklin County Health Department and its staff to receive the following medical services and care offered to me and/or persons listed above by this institution and to the release of any medical information necessary to process this claim for health care payment. I have read and understand the HIPPA Notice of Privacy Practices which is located on our web site at Franklinmo.org under Departments/Health/Nursing Services/HIPPA Notice of Privacy Practices.

Please circle required vaccines needed: Tdap Meningococcal
Circle any recommended vaccines desired: Meningococcal B HPV Flu

Signature of parent: _____ Date: _____

History reviewed ☐ VIS Given ☐ Nurse Int. _____ Date: _____