Franklin County Health Department Consent Form

Date of Birth: Gender: Race: Ethnicity:	Today's Date:	School Name:	•		
Date of Birth: Gender: Race: Ethnicity: Parent/Guardian: First Mil Last Last Phone Number:	Student's Name:	MI	Lact		Age:
Parent/Guardian: Tire	D . (D)			Eth	nnicity:
Address: Street City/State Zip Phone Number:	Parent/Guardian:				
Insurance Carrier: Patient's Medicaid # (if applicable): Policy Holder Name: Date of Birth:			IVII LASI	Dhana Numhan	
Policy Holder Name:		City/State Zip			
Member ID# Group ID# Emergency Contact Person: Contact Number: Set the child sick today? (We will ask child the day of the clinic.) Yes No Do not know as the child have allergies to medication, eggs, latex, or any vaccine?	Insurance Carrier:	Pa	tient's Medicaid # (if a	pplicable):	
Emergency Contact Person: Contact Number:	Policy Holder Name:	Date of Birth:			
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 have aserious 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: 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. Bywe 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	Member ID#		Group ID#		
Does the child have allergies to medication, eggs, latex, or any vaccine? Has the child have allergies to medication, eggs, latex, or any vaccine? Has the child 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: Inderstand 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. By we 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	Emergency Contact Per	son <u>:</u>	Co	ntact Number:	
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: Junderstand 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. In the 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. In the 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. In the 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 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: The Meningococcal Mening	Is the child sick today?	(We will ask child the day of the o	clinic.)	Yes No	Do not know
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	Please circle requi	ired vaccines needed:	Tdap Mening	gococcal	
Signature of parent: Date:	Circle any recomm	ended vaccines desired:	Meningococcal E	B HPV	Flu
Signature of parent: Date:					
	Signature of parent:				Date:

Nurse Int.

Date:

History reviewed

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