

Parent or Guardian of: _____

Vaccine consent form must be returned by: _____



Dear Parent / Guardian,

Students entering the 6th grade will require an additional dose of TDAP (tetanus-diphtheria toxoid & acellular pertussis) vaccine. Students must have this vaccine in order to enter 6th grade. This law became effective 2010 and may be found in Rules of the State Board of Health, Chapter 420-6-1.03(a).

If you would like to participate in our School Located Vaccination Clinic – **complete in full and sign** the consent form on the back of this form. Be sure to check the vaccines desired on the top of the form, if not checked- we will provide all the ACIP recommended vaccines that your child is currently due for. There is no out of pocket charge to parents for this service. If your child has Medicaid, AllKids, or private insurance, HNH will bill the insurance company for the vaccine. If your child is uninsured, the vaccine will be given free of charge.

If your child is covered by **PEEHIP** – we cannot provide vaccinations for your child. We apologize for this inconvenience- please contact PEEHIP at 1-877-517-0020.

Please see www.immunize.org or www.cdc.gov for current Vaccine Information Statement or more information regarding each of the vaccines recommended by CDC Advisory Committee on Immunization Practices (ACIP).

The following ACIP recommended vaccinations are available at the upcoming school located clinic:

Checked below are vaccines that your child should receive:

*(School Nurse- please use **ImmPrint forecast** to indicate non compliant vaccinations. A copy of the forecast must accompany the student consent form at the time of vaccination)*

- Tdap- Tetanus, diphtheria, pertussis : Boostrix® Ages 10 and older
- HPV- Human Papillomavirus: Gardasil® Ages 9-26 with a second dose after 6 months
- MCV- Meningococcal ACWY: Menveo® Ages 2 and up (with a booster dose recommended at age 16)
- MCVB – Meningococcal B: Bexsero® Ages 16-25 with a second dose after 30 days

Please return the consent form – completed – with the desired vaccines checked – only if you wish for your child to be vaccinated during the school clinic- if not, please discard this form and make an appointment with your child’s healthcare provider, local health department or pharmacy.

Feel free to contact us at 205-609-0268 with any questions or concerns,



HNH Immunizations Inc.

WWW.HEALTHHEROUSA.COM

HEALTH HERO

You Keep Them Smart
We Keep Them Healthy

Vaccine Consent Form: School _____

Please select the vaccine(s) you consent for your child to receive:

Tdap MCV MCV-B HPV (Cancer preventative)

PLEASE COMPLETE ALL OF THE INFORMATION BELOW Please print using ink (Incomplete forms will not be accepted)

FIRST NAME of Student:										LAST NAME of Student:									
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>					Birthdate: (month, day, year)					Age					Homeroom Teacher / Grade				
Address										Phone # ()									
City					Zip Code					State					Student Race: (Circle one) African American / Black White Alaskan/ Native American Asian Hispanic Non-Hispanic Hawaiian / Pacific Islander Other :				
Email address:																			

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.

Please fill out the following questions pertaining to your child's Health Insurance:

Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> My child does NOT have health insurance <input type="checkbox"/>										Insurance Company:									
Policy Holder's First Name:										Policy Holder's Last Name:									
Member ID: or SSN										Policy Holder's Date of Birth: (month/day/year)									

CHECK YES OR NO FOR EACH QUESTION

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has your child ever had a life threatening reaction(s) with any vaccines?
<input type="checkbox"/>	<input type="checkbox"/>	2. Does your child have any allergies to latex?
<input type="checkbox"/>	<input type="checkbox"/>	3. Has your child ever had a condition called Guillain Barré Syndrome (GBS)?
<input type="checkbox"/>	<input type="checkbox"/>	4. Has your child ever had seizures or another nervous system problem?
<input type="checkbox"/>	<input type="checkbox"/>	5. If applicable, is the student pregnant or nursing?

STOP
Please do NOT return this form unless you want your child to be vaccinated.

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL US AT 205-609-0268 TO SPEAK TO A REPRESENTATIVE.

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release the school system, HNH Immunizations, Inc. & subsidiaries, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. Clinic dates can be obtained from the school. I understand that the health related information on this form will be used for insurance billing purposes. I give permission to HNH Immunizations Inc to discuss or appeal any claims with my insurance carrier on my behalf.

Printed Name of Parent/Guardian Relationship Signature of Parent/Guardian Date

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