

2023 STUDENT MenACWY VACCINATION CONSENT FORM



Name:	Middle	Health Department Use Only					
	Gender: \square M \square F	Cli ID#:					
If minor - parent/guardian's name:		Encounter #:					
Parent/Guardian's Date of Birth: //	First M.I. Parent's SSN: optional						
Address: City	<u>.</u>	ZIP:					
Grade: Home Room Teacher:		School:					
IMPORTANT Parent/Guardian Phone # Home:	Cell:	Work:					
Emergency Contact: Er	nergency contact number:						
(If other than Head of Household)							
My child will be 11 years of age or older on the day of the	scheduled vaccination clin	nic: YES NO					
Please check YES or NO to all of the questions below to determine airling the vession will review this information on the		eive the MenACWY vaccine. The					
nurse giving the vaccine will review this information on the v	accine chine day.	YES NO					
1. Has your child had a serious allergic reaction to any vac	cine component?						
2. Has your child ever had a serious or life-threatening allergic reaction to a previous dose of							
Meningococcal vaccine? If you answered YES to questions 1, or 2 above about a serious allergy, or reaction to MenACWY vaccine, this vaccine							
may not be safe for your child and s/he WILL NOT receive this vacci threatening allergy, please speak with your child's doctor before con-		i severe ille-					
NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice: 1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids in a way that may transmit disease, I understand that the law requires my child to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. 2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.							
CONSENT FOR CHILD'S VACCINATION: I have read the 2021 Vaccination Information Statement (VIS) for the MenACWY Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the MenACWY vaccine (shot).							
Signature of Parent or Legal Guardian: X		Date:/					

Insurance*: Please answer the following: This information is required for federal funding purposes for VFC vaccines.

*Note: Vaccines will be provided to your child without charge if the child is eligible for the Vaccines for Children Program. If your child is covered by a private health insurance plan, the Department shall seek reimbursement for all allowable costs associated with the provision of the vaccine. Your child will not be vaccinated if you do not provide all requested insurance information below.

) is <i>not</i> insured (not covered by private insurance, Medicaid, Me	aid MCO or FAMIS)	
()) is American Indian or is an Alaska Native		
) has Medicaid MCO with: Virginia Premier, Optima Community Molina Healthcare, United Healthcare Community Plan, or Aetna I		
N	Member ID # as shown on your card:	is this a FAMIS	S plan? \square Y \square N
()) has Medicaid or FAMIS (circle one) that is not a MCO plan: Medicaid or FAMIS (circle one) that is not a MCO plan:	dicaid #:	
() has other insurance not listed above (specify plan)		
	Policy ID #Policy holder's		
	Attach a copy of the front & back of insurance card or provide Insurance company address	the following informa	
	Insurance company phone number		
I authorize \ and other he	VDH to release records necessary to support the application fealth care benefits. I request the third-party payer to pay any	or payment by Medica	
behalf.	Office of Delice and Consider		
	Office of Privacy and Security	1.1.6	
TDI:	Authorization for Disclosure of Protected Heal		1
	gives the Virginia Department of Health (VDH) permission to disclose pe s) I have indicated.	rsonal health information t	to the person(s) or
	derstand the provision of treatment to my child cannot be conditioned on a		ation.
•	health information redisclosed by me or my child will no longer be protected	•	
	original or a copy of the authorization shall be included with my child's n		
withh	we the right to revoke this authorization at any time, except to the extent the hold my medical record. The request must be in writing and will be effect by medical records.		
• I auth	thorize VDH to disclose my child's health information to his/her primary	are physician and school.	
• I und	derstand that immunization records of my child will be retained for 21 year	s after birth.	
schoo			maintained by the
☐ Please check	ck box if you wish to receive a copy of the Virginia Department of Health Notice	of Privacy Practices.	
Please send a	a copy of my child's immunization record to her/his doctor at the follo	wing address:	
Doctor's Name		State	ZIP
	HEALTH DEDARTMENT LISE ONLY		

HEALTH DEPARTMENT USE ONLY									
Date	Item code	Fund Source		Lot Number	Vaccine Administration Site		Provider #		
	MenACWY	VFC	STF		RA	LA			
Comments									
Provider Name/Signature and Date									