If shots wanted, submit completed form by March 12, 2025

ONSLOW COUNTY SCHOOL
Immunization Outreach Clinic 2024-2025

A. STUDENT'S SCHOOL INFORMATION

School's Name:		Grade:		Teacher:	

B. STUDENT'S PERSONAL DATA

Student's Full Name (Last, First MI Suffix)		**Birth Date (mm/dd/yyyy)**		Age	

Sex: ☐ Male ☐ Female | **SSN (xxx-xx-xxxx)** | **Hispanic Origin:** ☐ Yes ☐ No

Mother's Maiden Last Name, First Name assist in the client de-duplication process in N.C. Immunization Registry (NCIR):

Race: ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Native Hawaiian / Other Pacific Islander ☐ Decline to Specify

Complete Mailing Address (Street, City, State, Zip):	

Home Phone:	Cell Phone:	Work Phone:

C. HEALTH INSURANCE INFORMATION (Attach a copy of the front and back of your insurance card(s), if applicable)

☐ **In**sured, provide insurance(s) information below. ☐ **Un**insured, contact O.C. DSS (910) 455-4145 to apply for Medicaid

Primary Insurance Name		**Insurance Policy # or Tricare DoD Benefit #**	
Primary Subscriber Name		**Primary Subscriber DOB:**	

Student's Relationship to Subscriber: ☐ **Self** ☐ **Child** ☐ **Other:** | IMMUNIZATIONS COVERED? ☐ YES ☐ NO

Secondary Insurance Name		**Insurance Policy # or Tricare DoD Benefit #**	
Secondary Subscriber Name		**Primary Subscriber DOB:**	

Student's Relationship to Subscriber: ☐ **Self** ☐ **Child** ☐ **Other:** | IMMUNIZATIONS COVERED? ☐ YES ☐ NO

When applicable, I, the patient named above, or the patient's authorized representative, understand that I may be financially responsible to Onslow County Health Department (OCHD) for charges not covered by my medical insurance carrier(s). I authorize payment of medical benefits to OCHD on my behalf for services provided unless other arrangements have been made. I authorize the use of the signature below on all insurance submissions whether manual or electronic. In addition, I agree to repay OCHD any money I receive from my medical insurance carrier for services provided to me by OCHD for which I have not paid.

D. HIPAA, STATEMENT TO CONSENT TO VACCINE, & RELEASE OF SHOT RECORDS

By my signature below, I show that I am legally authorized to give this consent and I:

- I am either the patient or the patient's personal representative.
- I have received a copy of the "Notice of Privacy Practices" from Onslow County Health Department via the OCHD website Bit.Ly/ochdchildvaccines
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.
- Have received the "Vaccine Information Statements (VIS) about the disease(s) and vaccine(s)
- Have had a chance to review the statements and to ask questions that were answered to my satisfaction.
- Understand the benefits and risks of the vaccine(s).
- I consent for release of shot records from Onslow County Schools to Onslow County Health Department.
- Request the vaccine(s) indicated below be given to me or the person named above.

I want my child to receive the shot(s) checked:	☐ 7th Grade **Required**: Meningococcal & Tdap	☐ 12th Grade **Required**: Meningococcal

Optional Vaccines: ☐ HPV ☐ Hepatitis A

ALLERGIES / COMMENTS:

Has your child had a severe reaction to a prior dose of the checked vaccine(s) or any of its components? ☐ Yes ☐ No

Patient/Parent/Guardian Print Name: | Signature x: | Date:

Instructions for electronic submission:

1. Complete this form in its entirety
2. Take a picture with your phone camera
3. Email the picture of the completed form to: OCHD-Vaccine@onslowcountync.gov

Patient's Printed Name (Last, First MI Generation) ______________________

Date of Birth:______________________

Onslow County School
Initiative Immunization Outreach Clinic
2024-2025

SECTIONS BELOW COMPLETED BY OCHD IMMUNIZATION STAFF

Clinical Comments:		☐ P ☐ S ☐ Hep A ☐ Tdap ☐ Menin ☐ HPV									
H. SHOT(S) ADMINISTERED (SECTION BELOW TO BE COMPLETED BY OCHD STAFF)											
Vaccine Administration(s):			☐ **90471EP Injection #1**		☐ **90472EP + additional injection(s)**						
Immunization		**Dx**	**Purchase / State**		**Admin Site (Circle**				**Manufacturer & Lot No.**		**VIS**
☐ 90715+	Tdap	Z23	P	S	LD	RD	LT	RT			08/06/21
☐ 90734+	Meningococcal	Z23	P	S	LD	RD	LT	RT			08/06/21
☐ 90651	HPV	Z23	P	S	LD	RD	LT	RT			08/06/21
☐ 90633	Hepatitis A	Z23	P	S	LD	RD	LT	RT			10/15/21
I have asked about prior immunizations and reactions. According to informed, no reactions have occurred.			Provider's Signature						Date	NCIR	CureMD

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