

Vaccine Consent

Complete and return to your school no later than September 1.

I would like my student to receive the following:

Menactra

Gardasil

| | | | | |
|--|-------|-------------------|-------|----------|
| PRINT the name of Student to receive vaccine | | | | |
| Last | First | Middle | | |
| Address | Apt. | City | State | Zip Code |
| Birth date | Age | Emergency Phone # | | |
| <p>Does your child have any allergies or any medical concerns? Please list: _____</p> <p>The following best describes my child's insurance status: <input type="checkbox"/> My student is covered by Medicaid, or <input type="checkbox"/> My student is NOT covered by health insurance, or <input type="checkbox"/> My student is covered by insurance; however, our insurance does not cover vaccinations. There is a \$45 requested donation for the Gardasil three dose series, There is \$15 requested donation for the Menactra vaccine. Make checks payable to Community Health Partners.</p> <p><input type="checkbox"/> My student is covered by health insurance that covers the vaccinations, Gardasil and Menactra. I have checked with my health insurance and the Gardasil and Menactra vaccine are covered. An insurance claim will be submitted by the Sioux Center Medical Clinic and I expect to pay any non-covered expenses. Submitted costs are: \$181 for Menactra and \$723 for the Gardasil series. Please include payment for copays and make check payable to Sioux Center Medical Clinic. Please provide the following information for insurance billing or attach a copy of your insurance card:</p> <p style="margin-left: 40px;">Name of insured _____ Date of Birth of Insured _____ Employer _____ Insurance Company Name _____ Address _____ City _____ State _____ Zip _____ Telephone Number _____</p> | | | | |
| <p>I have been given a copy and understand the HPV and Meningococcal Vaccine Information Sheet. I was given a chance to ask question and my questions were answered to my satisfaction. I understand the benefits and risks of the vaccine. I permit the person named above to be given the vaccine as indicated above. I am the parent or legal guardian of this person.</p> <p>SIGNATURE of Parent/Guardian _____ Please print name of parent _____</p> | | | | |

| School | Grade | | | |
|--------|----------|------|-------|-----------------|
| Date | Vaccine | Site | Lot # | Administered By |
| | Menactra | | | |
| | Gardasil | | | |
| | Gardasil | | | |
| | Gardasil | | | |