 School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_

 4527 E. 82nd Street Indianapolis, IN 46250

317-528-6374

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Gender: M or F

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Home Phone/ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have health insurance? YES or NO Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mothers Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle any optional Vaccinations you would like your child to receive**:**

HPV, Flu Shot, Bexsero (Meningococcal Group B)

**YOUR CHILD NEEDS THE FOLLOWING VACCINATIONS TO STAY IN SCHOOL:**

SCHOOL STAFF, PLEASE CIRCLE NEEDED VACCINE:

**Dtap, Hep A, Hep B, MMR, Varicella, Meningitis MCV4, Tdap**

**IMPORTANT NOTICE**

**If you do not have insurance, or your insurance company does not cover vaccinations there is a $10 fee PER vaccination received.**

**If you cannot afford any or all the vaccinations please call our office to see if you qualify for assistance. 317-528-6374**

 **Medical History: The following will help us determine your eligibility for requested immunizations. Please answer to the best of your ability.**

|  |  |  |
| --- | --- | --- |
| **1.** Are you Pregnant or planning a pregnancy in the next 4 weeks?  | **YES** | **NO** |
| **2.** Are you currently ill with a fever, vomiting or diarrhea? | **YES** | **NO** |
| **3.** Have you received blood/plasma/immune globulin or had a vaccine in the last 4 weeks?  | **YES** | **NO** |
| **4.** Have you ever fainted, became dizzy or had a serious reaction after an immunization?  | **YES** | **NO** |
| **5.** Have you ever had a seizure disorder for which you require medication, a brainDisorder, Guillain-Barre Syndrome or any other nervous system disorder?  | **YES** | **NO** |
| **6.** Are you allergic to any medications, foods or vaccines and their components? (such as eggs, bovine protein,toxoids,sorbitol,neomycin,phenol,yeast,thimerosal,latex,protamine sulfate or formaldehyde) | **YES** | **NO** |

 **ACKNOWLEDGEMENT/ RELEASE OF LIABILITY AND CONSENT TO RECEIVE IMMUNIZATION(S):**

* WRITTEN MD APPROVAL IS REQUIRED FOR CHILDREN UNDER THE AGE OF 8 YEARS FOR POLIO, RABIES AND MMR. YELLOW FEVER REQUIRES WRITTEN MD APPROVAL FOR PERSONS WITH MULTIPLE SCLEROSIS**,** CHILDREN UNDER 9 YEARS OR ADULTS OVER 59 YEARS. HEPATITIS A, B OR COMBO VACCINES ALSO REQUIRE MD APPROVAL FOR PERSONS WITH MS.
* **I** HAVE READ OR HAVE BEEN OFFERED A COPY OF THE CURRENT VACCINE INFORMATION SHEET PRIOR TO MY VACCINATION. I HAVE HAD A CHANCE TO ASK QUESTIONS AND I UNDERSTAND ALL THE RISKS AND BENEFITS INVOLOVED.
* I AGREE TO STAY IN THE AREA FOR 15 MINUTES AFTER RECEIVING MY VACCINATION TO ENSURE THAT NO IMMEDIATE REACTIONS OCCUR. I UNDERSTAND THAT IF I EXPERIENCE ANY SIDE EFFECTS IT WILL BE MY RESPONSIBILITY TO GOLLOW UP WITH MY PHYSICAN AT MY EXPENSE. LOCAL REACTIONS MAY INCLUDE BURNING, SWELLING, WHEAL, TENDERNESS OR BLISTERING AT SITE. GENERAL REACTIONS MAY INCLUDE FEVER, FATIGUE, DIARRHEA, NAUSEA, VOMITING, HEADACHE, ARTHRITIS, MALAISE AND MYALIA. SEVERE REACTIONS INCLUDE ANAPHYLAXIS, ENCEPHALITIS, GUILLAIN-BARRE AND FEBRILE CONVULSIONS.
* I UNDERSTAND THE VACCINE IS BEING PROVIDED BY FRANCISCAN WORKINGWELL. I EXPRESSLY RELEASE FROM ANY LIABILITY THE ABOVE NAMED ORGANIZATION AND INDIVIDUAL GIVING THE VACCINE(S). I, FOR MYSELF, MY HEIRS, EXECUTORS AND ASSIGNS HEREBY AGREE TO RELEASE THE SITE PROVIDER AND ITS EMPLOYEES FROM ANY AND ALL CLAIMS ARISING OUT OF, IN CONNECTION WITH OR IN ANY WAY RELATED TO MY RECEIPT OF THIS VACCINE(S) IN THEIR FACILITIES.
* I HAVE READ THIS CONSENT AND I AUTHORIZE FRANCISCAN WORKINWELL TO GIVE THE ABOVED NAMED VACCINE TO ME OR THE PERSON NAMED FOR WHICH I AM AUTHORIZED TO SIGN.
* I ACKNOWLEDGE THAT SOME VACCINES REQUIRE MULTIPLE DOSES AND/OR UP TO 2 WEEKS TO RECEIVE FULL PROTECTION.
* **ASSIGNMENT OF BENEFITS**: I HEREBY AUTHORIZE ANY INSURANCE WITH WHOM I HAVE APOLICY TO PAY DIRECTLY TO THE HEALTHCARE PROVIDERS ANY BENEFITS OTHERWISE PAYABLE TO ME. I HEREBY TRANSFER AND ASSIGN THE BENEFITS OF ANY POLICIES OF INSURANCE TO THOSE HEALTHCARE PROVIDERS WHO HAVE RENDERED SERVICES TO ME AND WHO ACCEPT SUCH ASSIGNMENT. I UNDERSTAND THAT I WLL BE FULLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL CHARGES NOT PAID BY MEDICAL INSURANCE. IF ANY AMOUNTS FOR WHICH I AM RESPONSIBLE BECOME DELINQUENT, I AGREE TO BE RESPONSIBLE FOR ANY EXPENSES PAID BY FRANCISCAN ALLIANCE AND HEALTHCARE PROVIDERS TO COLLECT THE AMOUNTS, INCLUDING REASONABLE ATTORNEY FEES.
* I UNDERSTAND THAT THERE MAY BE A DELAY, WHICH COULD BE MORE THAN 6 MONTHS, BETWEEN THE TIME I SIGN THIS CONSENT AND WHEN THE IMMUNIZATIONS ARE GIVEN TO MY CHILD. AS SUCH, I AGREE THAT IT IS MY SOLE RESPONSIBILITY TO MAINTAIN A COPY OF THIS CONSENT, TO NOTIFY THE SCHOOL OR FRANCSICAN IMMUNIZATIONS, AND TO PROVIDE AN UPDATED CONSENT IF MY ANSWERS CHANGE, OR MY CHILDS HEALTH CHANGES.

**PLEASE NOTE THAT IF YOU HAVE NOT ANSWERED OR FILLED OUT ALL INFORMATION WE WILL NOT VACINATE YOUR CHILD.**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature (parent or guardian if patient is under 18), Offered/Read HIPAA Privacy Practices Date

**Additional lines are for second and third dose consent.**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature (parent or guardian if patient is under 18), Offered/Read HIPAA Privacy Practices

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature (parent or guardian if patient is under 18), Offered/Read HIPAA Privacy Practices

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*Office USE ONLY\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **VACCINE / VIS Date**  | **DOSAGE/ SITE** | **LOT #/ EXP Date**  | **NURSES SIGNATURE** | **DATE GIVEN**  | **PAYMENT/BILLED** | **CHIRPED** |  |  |  |
| DTAP (Infanrix) **5/17/07** | 0.5 CC IM  |  | 1 |  |  |  |  |  |  |
| 5 doses required. Dosage: 2 months,4 months, 6months,15-18 months, 4-6 years  | Left or Right |  | 2 |  |  |  |  |  |  |
| Flu Vaccine **8/7/15** | 0.5 CC IM Left or Right |  | 1 |  |  |  |  |  |  |
| HEPATITIS A (Havrix) **7/20/16**12 months & up | 0.5 CC IM |  | 1 |  |  |  |  |  |  |
| Dosage: now and 6-12 months  | Left or Right |  | 2 |  |  |  |  |  |  |
| HEPATITIS B (Engerix B) **7/20/16** | 0.5 CC IM |  | 1 |  |  |  |  |  |  |
| Dosage: now, 1 month, 6 month  | Left or Right |  | 2 |  |  |  |  |  |  |
|  |  |  | 3 |  |  |  |  |  |  |
| HPV9 (Gardasil9) **3/31/16**  | 0.5 CC IM |   | 1 |  |  |  |  |  |  |
| can start at age 9Dosage: now, 2 months, 6 months | Left or Right |  | 2 |  |  |  |  |  |  |
|  |  |  | 3 |  |  |  |  |  |  |
| Meningococcal Group B **8/14/15** (BEXSERO)Dosage: month apart | 0.5 CC IM |  | 1 |  |  |  |  |  |  |
| Left or Right |  | 2 |  |  |  |  |  |  |
| MCV4 **3/31/16**Dosage:Two doses: the first dose at 11 or 12 years of age, with a booster dose at age 16. | 0.5CC IM |   | 1 |  |  |  |  |  |  |
| Left or Right |  | 2 |  |  |  |  |  |  |
| MMR **4/20/12****First Dose**: 12-15 months of age**Second Dose**: 4-6 years of age (may be given earlier, if at least 28 days after the 1st dose | 0.5 CC SUBQ |  | 1 |  |  |  |  |  |  |
| Left or Right |  | 2 |  |  |  |  |  |  |
| MMR-V (ProQuad) **5/21/10** **Do not give if**: history of anaphylactic reaction to neomycin or hypersensitivity to gelatin | 0.5 CC SUBQ |  | 1 |  |  |  |  |  |  |
| Left or Right |  | 2 |  |  |  |  |  |  |
| PCV13 (PREVNAR13**) 11/5/15**Dosage 2,4,6,12-15 months | * 1. CC IM
 |  | 1 |  |  |  |  |  |  |
| 24 months and up to 6th birthday never had vaccine they should only receive 1 dose | Left or Right |  | 2 |  |  |  |  |  |  |
| Tdap (Boostrix, Adacel) **2/24/15** 10 years and older  | 0.5 CC IMLeft or Right |  | 1 |  |  |  |  |  |  |
| VARICELLA (**LIVE)** **3/13/08** | 0.5 CC SUBQ |  | 1 |  |  |  |  |  |  |
| first dose at 12 through 15 months old second dose at 4 through 6 years | Left or Right |  | 2 |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
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