Platte County Health Department

Serving Platte County Missouri

Allergies: _____ Reaction _____

Patient Information

Child's School: _____ Sex: ☐ Female ☐ Male Child's Age: _____

Name: (Last) _____ (First) _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Phone: Home _____ Cell _____

Race:

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other

Ethnicity:

☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Other

Clinic Date

I would like my child to attend:

☐ Platte County Health Department in Platte City August 5th between 3pm-7pm. Registration due July 27th.

☐ Platte County Health Department in Platte City August 7th between 9am-1pm. Registration due July 27th.

☐ Riverside Fire Department in Riverside August 19th between 3pm-7pm. Registration due August 10th.

☐ Riverside Fire Department in Riverside August 21th between 9am-1pm. Registration due August 10th.

Authorization and Consent

I would like my child to receive:

☐ Meningococcal ACWY (Meningitis) (Middle and High School)

☐ Tdap (Tetanus, Diphtheria, & Pertussis) (Middle School only)

☐ Hepatitis A

☐ Human Papillomavirus (HPV)

☐ Meningococcal B (Meningitis) (16 & older)

Personal Financial Responsibility: By signing this form, and in return for the services rendered by the Platte County Health Department (PCHD), I am personally responsible for all fees not paid by any third party on my behalf.

Assignment of Insurance Benefits: I hereby assign all my interest and rights to all insurance benefits otherwise payable to me from any policy to PCHD. I agree that PCHD may disclose any portion of my medical, financial, or personal information to any person or organization requiring such information as a condition of paying, receiving payment for, or justifying payment for my health care or the health care of one for whom I am responsible. I further authorize payment of all insurance benefits, otherwise payable to me, for all treatment provided directly to PCHD.

My signature indicates that I have reviewed a copy of the "Notices of Privacy Practices" and have read the Vaccine Information Statement (VIS) for each vaccine that I am requesting be given to the person named on the form.

Signature of Patient, Parent, or Legal Guardian: _____

Print Name: _____ Date: _____

Relationship to Student (self, parent, or guardian): _____

Platte County Health Department
Serving Platte County Missouri
1201 E St. Parkville, MO 64152

School Name:_____

Student Name:_____

Please answer questions about the person receiving the vaccine(s) by checking yes or no.

The following questions will help us determine which vaccines you may be given today. If you answer yes to a question, it does not necessarily mean you should not be vaccinated. It means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Do you have allergies to medications, food, a vaccine component, or latex? Yes ☐ No ☐
   If yes, what is your student allergic to?_____Reaction?_____
2. Have you had a serious reaction to a vaccine in the past? Yes ☐ No ☐
3. Do you have a health problem with lung, heart, kidney, or metabolic disease (i.e., diabetes), asthma, or a blood disorder? Are you on a long term aspirin therapy? Yes ☐ No ☐
   If yes, please explain:_____
4. Have you ever had a seizure, or had a brain or other nervous system problem? Yes ☐ No ☐
5. Do you have or live with someone who has cancer, leukemia, HIV/AIDS, or immune system problems? Yes ☐ No ☐
6. In the past 3 months, have you taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Yes ☐ No ☐
7. In the past year, have you received a blood transfusion or blood products, or have been given a medicine called immune (gamma) globulin or an antiviral drug? Yes ☐ No ☐
8. Have you received any vaccinations in the past 4 weeks? Yes ☐ No ☐
9. Did you bring your immunization record with you? Yes ☐ No ☐

Additional Questions for Females Only:

10. Are you nursing, pregnant, or is there a chance you could become pregnant during the next month? If pregnant, how many weeks:_____ Yes ☐ No ☐
11. Are you currently using a birth control method? Yes ☐ No ☐
12. To be answered the day of clinic: Are you sick today? Yes ☐ No ☐

FORM COMPLETED BY:_____DATE:_____(Patient/Parent/Guardian Signature)

FORM REVIEWED BY:_____DATE:_____(Nurse Signature)

----------FOR CLINIC NURSE USE ONLY----------

Men ACWY	TDAP	HPV
Men B	Hepatitis A	Eligibility Status