PORTER COUNTY Indiana

Health Department

Pediatric/Adolescent Vaccination Clinic Consent Form

Office Use Only SIIS#

- ☐ I am the patient's PARENT and give permission for the vaccines to be administered today.
- ☐ I am the legal guardian & have documents proving my guardianship for the child/minor to receive vaccines today.
- ☐ I am not the parent and I have written permission for the child/minor to receive vaccines today.

PLEASE PRINT

Patient's Last Name:	First Name:	MI:	Date of Birth MMDDYYYY	Age:
			- -	
Listed under any alias or other name? If so, Last Name Used	First Name Used:		Gender ✓	Physician's Name:
			☐ Male ☐ Female	
Patient's Race ✓: ☐African American ☐ Caucasian ☐ American Indian/Eskimo ☐ Other ☐ Multiracial ☐ Hispanic	U.S. State or Foreign Country of Birth:		What Language is spoken at home?	
Patient's Current Mailing Address:	City:	State	ZIP Code:	Home/Primary Phone Number:
				( ) -
Mother or Legal Guardian's Last Name:	Mother First Name:	MI	Maiden Name:	Mother's Contact Phone Number:
				( ) -
Father or Legal Guardian's Last Name:	Father First Name:	MI		Father's Contact Phone Number:
				( ) -

Current Medical Coverage

☐ **Patient has Medicaid** *(indicate program information below)*	☐ Check here if Private Insurance Is Used & Read Disclosure Below*:
Medicaid Number:	*If insurance coverage is declined or rejected after submission it will be your responsibility to pay any outstanding amounts due us. We will process your claim through a third party service it is they who will determine final eligibility. There could be a delay as long as 60 plus days for final settlement.*
Program Number:	Insurance Company Name:
☐ **Patient is NOT Covered by any Medical Insurance** *(We may require payment at time of vaccination if eligibility for free programs cannot be verified)*	Policy Number:
	Group Number:
☐ **Patient has insurance but vaccines are not covered**	Policy Holder's Full Name:
☐ **Patient is American Indian or ☐ Eskimo**	Holder's Date of Birth: --- ---

Screening: Please answer all questions. Answers determine which vaccines the person named above <u>can</u> receive today. ✓	YES	NO
1. Is the child sick today? Please Explain:		
2. Does the child have allergies to medications, food, or any vaccine? List:		
3. Has the child had a serious reaction to a vaccine in the past?		
4. Has the child or immediate family member (father, mother, sibling) had a seizure or any brain disorder?		
5. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
6. Does a parent, brother or a sister have a history of immune system problems?		
7. Does the child have a low platelet count or blood disorder?		
8. In the past 3 months has the child taken cortisone, prednisone or other steroids for longer than 14 days? Has the child taken any cancer fighting treatments (radiation/chemotherapy) in the past year?		
9. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?		
10. Has the child received vaccinations in the past 4 weeks? If yes, list:		
11. Has the child/teen ever fainted?		
12. If the child/teen is female, is there a chance she is pregnant or could become pregnant during the next month?		

**** I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY FEES INCURRED NOT COVERED BY MY INSURANCE. ****

Consent to Vaccinate: Parent/Guardian must sign form for a child to receive vaccines.

By signing below you are stating all the information on this form is correct.

Note: We require previous vaccination records for all patients who have received them elsewhere.

	- -		- -
Parent/Guardian Signature	Date (mm/dd/yy)	Nurse's Signature	Date (mm/dd/yy)
Print Name/Relationship to Patient			