PORTER COUNTY Indiana

Health Department — Pediatric/Adolescent Vaccination Clinic Consent

- ❒ 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.
- ❒ I am a grandparent acting in a custodial capacity in the absence of the child's natural parents.

Office Use Only SIIS#

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 ❒ Am. Indian/Eskimo ❒Multiracial ❒Other ❒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)***

Medicaid Number:

Program Number:

❒ **Patient is NOT Covered by any Medical Insurance** *(We may require payment at time of vaccination if eligibility for free programs cannot be verified)*

❒ **Patient has insurance but vaccines are not covered**

❒ **Patient is American Indian or ❒ Eskimo**

❒ **Check here if Private Insurance Is Used & Read Disclosure Below*:**

**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.*

Insurance Company Name:	
Policy Number:	
Group Number:	
Policy Holder's Full Name:	
Holder's Date of Birth:	--- ---

Screening: Please answer all questions. Answers determine which vaccines the person named above can 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 information on this form is correct and that you had the opportunity to review our HIPAA Compliance Policy if desired. ***Note: We require previous vaccination records for all patients who received vaccines elsewhere.***

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

VACCINE ADMINISTRATION PATIENT RECORD

LAST NAME:	FIRST NAME:	MIDDLE NAME:

DATE OF BIRTH (mm/dd/yyyy):	AGE:	Contraindication:
- -		

DO NOT WRITE BELOW THIS LINE-FOR CLINIC USE ONLY

CLINIC- PORTER COUNTY HEALTH DEPARTMENT:
- ❒ 155 INDIANA AVE., VALPARAISO, IN 46383
- ❒ 3610 WILLOWCREEK RD, PORTAGE, IN 46368
- ❒ (other):

DATE VACCINATED AND
DATE VIS PROVIDED TO PARENT / GUARDIAN / PATIENT
Vaccine Charge:
❒ VaxCare ❒ VFC ❒ Other_____

VACCINE	DOSE	MANUFACTURER & LOT NO.	ROUTE / SITE	DATE OF VIS	CPT CODE
PEDIARIX GSK DTaP-HepB-IPV 0.5ml.			IM/	4-01-20 /8-15-19 7-20-16/4-1-2020	**90723**
HIB 0.5 ml.			IM/	10-30-19/4-1-2020	**90648**
PCV^{13} PPSV^{23} 0.5ml			IM/	10-30-19/4-1-20 10-30-19	**90670** **90732**
ROTAVIRUS GSK / RV1 1.0 ml MERCK / RV5 2.0 ml.			ORAL	10-30-19/4-1-2020	**90681** **90680**
PENTACEL DTaP-Hib-IPV 0.5ml			IM/	4-1-20 / 10-30-19 10-30-19/4-1-2020	**90698**
VARICELLA 0.5ml.			SUB *QI*	8-15-19	**90716**
MMR 0.5ml.			SUB *QI*	8-15-19	**90707**
MMRV 0.5ml.			SUB *QI*	8-15-19	**90710**
HEPA 0.5ml.			IM/	7-20-16	**90633**
DTap Td Tdap 0.5ml.			IM/	4-1-20 / 4-1-2020 8-24-18 / 4-1-2020	**90700 90714 90715**
IPV 0.5ml.			SUB *QI*	10-30-2019/4-1-20	**90713**
HEP B 0.5ml.			IM/	8-15-19/4-1-2020	**90744**
Meningococcal ACWY Menactra, MenQuadfi 0.5ml.			IM/	8-15-19	**90734 90619**
Meningococcal B Bexsero 0.5ml			IM/	8-15-19	**90620**
INFLUENZA – IM 0.5ml FluMist			IM	8-15-19	**VARIES** Input Code:_____
HPV 9 0.5ml.			IM/	10-30-2019	**90651**
KINRIX DTap-IPV 0.5ml.			IM/	4-1-2020 / 10-30-19	**90696**

Nurse's Authorization		Office Use Only: Input Responsibilities			
Date	Nurse's Signature	CHIRP Date	CHIRP Initials	UPP Date	UPP Initials