Onslow County School
Initiative Immunization Outreach Clinic 2016-2017

Print Form

A. STUDENT'S SCHOOL INFORMATION

School's Name:		Teacher's Name	

B. STUDENT'S PERSONAL DATA

Student's Printed Name (Last, First MI Suffix)		**Birth Date MM/DD/YYYY**		**Age**	

Sex: ◯ Male ◯ Female | **SSN** | Hispanic Origin? ◯ Yes ◯ No

Mother's Maiden Last Name, First Name assists in the client de-duplication process in N.C. immunization Registry (NCIR)

Race: ◯ White ◯ Black ◯ American Indian ◯ Asian ◯ Native Hawaiian/Other Pacific Islander ◯ Unknown

Complete Mailing Address:

Home Phone:		Cell Phone:		Work Phone:	

C. STATEMENT OF CONSENT TO VACCINE. By my signature below, I show that I am legally authorized to give this consent and I:

- Have received the "Vaccine Information Statements" about the disease(s) and vaccine(s).
- Have had a chance to review the statements and to ask questions that were answered to my satisfaction.
- Understand the benefits and risks of the vaccine(s).
- Request the vaccine(s) indicated below be given to me or the person named above.
- Understand that in signing I am consenting to a maximum of three (3) HPV vaccines in order to properly complete the HPV series.

I want my child to receive: (please check 1 box)

- ☐ Neither Vaccines
- ☐ Tdap **ONLY** (complete E-F)
- ☐ Meningococcal **ONLY** (complete E-F)
- ☐ All 3 Vaccines (complete E-F)
- ☐ HPV **ONLY** (complete E-F). Give date(s) of prior HPV:

D. ALLERGIES / COMMENTS:

Has your child had a severe reaction to a prior dose of the checked vaccine(s) or any of its components? Yes ◯ No ◯

Printed Name		Signature x:	Date	

E. HEALTH INSURANCE INFORMATION (Attach a copy of the front and back of your insurance card(s), if applicable)

☐ Insured, provide insurance(s) information below. ☐ Uninsured. Contact O.C. DSS (910) 455-4145 to apply for Medicaid.

Primary Insurance Name:		Policy # or Sponsor SSN:	
Primary Subscriber Name:		Primary Subscriber DOB:	

Student's Relationship to Subscriber: ◯ Self ◯ Child ◯ Other: | Immunizations Covered? Yes ◯ No ◯

Secondary Insurance Name:		Policy # or Sponsor SSN:	
Secondary Subscriber Name:		Secondary Subscriber DOB:	

Student's Relationship to Subscriber: ◯ Self ◯ Child ◯ Other: | Immunizations Covered? Yes ◯ No ◯

Assignment of Insurance Benefits: When applicable, I, the patient name above, or the patient's authorized representative, understand that I may be financially responsible to Onslow County Health Department (OCHD) for charges not covered by my medical insurance carrier(s). I authorize payment of medical benefits to OCHD on my behalf for services provided, unless other arrangements have been made. I authorize the use of this signature on all insurance submissions whether manual or electronic. In addition, I agree to repay OCHD any money I receive from my medical insurance carrier for services provided to me by OCHD for which I have not paid.

Signature (Parent or Legal Representative) *x*	Date	

F. HIPAA. By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Onslow County Health Department (OCHD);
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Printed Name of Student's legal guardian / legally responsible person:	Signature *X*:
Relationship to Student:	Date:

Patient's Printed Name (Last, First MI Suffix) _____ Patient's Birth Date _____

Onslow County School Initiative Immunization Outreach Clinic 2016-2017

Clinical Comments:

G. SHOT(S) ADMINISTERED (Section below to be completed by OCHD Staff)

Vaccine Administration(s): ☐ 90471EP Injection #1 ☐ 90472EP + additional injection(s)

Immunization		Dx	Purchase / State		Admin Site (Circle One)				Manufacturer & Lot No.	VIS
90715+	Tdap	V23	P	S	LD	RD	LT	RT		05/09/13
90734+	Meningococcal	V23	P	S	LD	RD	LT	RT		10/14/2011
90651+	HPV #1	V23	P	S	LD	RD	LT	RT		04/15/15
90651+	HPV #2	V23	P	S	LD	RD	LT	RT		04/15/15
90651+	HPV #3	V23	P	S	LD	RD	LT	RT		04/15/15

I have asked about prior immunizations and reactions. According to informant, no reactions have occurred.	Provider's Signature	Provider #	Date	NCIR	HIS

Clinical Comments:

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90651+	HPV #2	V23	P	S	LD	RD	LT	RT		04/15/15
90651+	HPV #3	V23	P	S	LD	RD	LT	RT		04/15/15

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