Bring this completed form to your Saturday appointment with any shot record OCHD may **not** have.

Onslow County Health Department (OCHD)
Saturday Back to School Immunization Clinic 2020

Print Form

A. STUDENT'S / PATIENT'S PERSONAL DATA

Student's / Patient'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:	

B. 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 / I want my child to receive the shot(s) checked to the right: ☐ Flu (if available) ☐ Tdap ☐ HPV (3) ☐ Meningococcal

Printed Name		Signature x:		Date	

C. ALLERGIES / COMMENTS:

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

D. 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:		Insurance Policy # or Tricare DoD Benefit #	
Primary Subscriber Name:		Primary Subscriber DOB:	
Student's / Patient's Relationship to Subscriber: ◯ Self ◯ Child ◯ Other:		Immunizations Covered?	Yes ◯ No ◯
Secondary Insurance Name:		Insurance Policy # or Tricare DoD Benefit #	
Secondary Subscriber Name:		Secondary Subscriber DOB:	
Student's / Patient's Relationship to Subscriber: ◯ Self ◯ Child ◯ Other:		Immunizations Covered?	Yes ◯ No ◯

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.

E. 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 / Patient's legal guardian / legally responsible person:	Signature *X*:
Relationship to Student / Patient's:	Date:

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

Onslow County Health Department
Saturday Back to School
Immunization Clinic 2020

SECTIONS BELOW TO BE COMPLETED BY IMMUNIZATION STAFF

Clinical Comments:

☐ **S** ☐ Flu ☐ Tdap ☐ Menin ☐ HPV

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

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

Immunization		Dx	State	Admin Site (Circle One)				Manufacturer & Lot No.	VIS
90686+	Flu	Z23	**S**	LD	RD	LT	RT	37BH7	08/15/2019
90715+	Tdap	Z23	**S**	LD	RD	LT	RT	374LB	04/01/2020
90734+	Meningococcal	Z23	**S**	LD	RD	LT	RT	U6691AA	08/15/2019
90651+	HPV #1	Z23	**S**	LD	RD	LT	RT	1637642	10/30/2019
90651+	HPV #2	Z23	**S**	LD	RD	LT	RT	1637642	10/30/2019
90651+	HPV #3	Z23	**S**	LD	RD	LT	RT	1637642	10/30/2019

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

Clinical Comments:

☐ **P** ☐ Flu ☐ Tdap ☐ Menin ☐ HPV

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	Admin Site (Circle One)				Manufacturer & Lot No.	VIS
907686+	Flu	Z23	**P**	LD	RD	LT	RT	UJ431AA	08/15/2019
90715+	Tdap	Z23	**P**	LD	RD	LT	RT	49R79	04/01/2020
90734+	Meningococcal	Z23	**P**	LD	RD	LT	RT	U6575AA	08/15/2019
90651+	HPV #1	Z23	**P**	LD	RD	LT	RT	S02737	10/30/2019
90651+	HPV #2	Z23	**P**	LD	RD	LT	RT	S02737	10/30/2019
90651+	HPV #3	Z23	**P**	LD	RD	LT	RT	S02737	10/30/2019

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