HARDY COUNTY HEALTH DEPARTMENT

REGISTRATION/ **IMMUNIZATION CONSENT FORM**-School Immunization Clinic

School________________________________ Grade______________

Name: Last____________________First________________ Middle ___

Birthdate:____________________

Address:____

City:_____________________ State:_________ Zip:______________

I also **authorize the Hardy County Health Department to release any information required** and/or requested by my Insurance company/ Medicaid in regards to payment.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices for the Hardy County Health Department. This notice explains how my protected health information is used and/or disclosed for purpose of treatment, payment, and health care options. (copy available at the Hardy County Health Department.)

The School Nurse has high-lighted the Required Vaccine(s) your child needs!

Circle **YES** or **NO** to Vaccinate	**YES or NO**	**YES or NO**	**YES or NO**	**YES or NO**
Vaccines	**Tdap Required**	**Meningitis Required**	**Meningitis B #1** ***Recommended***	**Meningitis B #2** Given 1 month later after getting 1st Dose ***Recommended***
Date Vaccine Administered				
Vaccine Manufacturer				
Vaccine LOT #				
VIS Date				
Site of Injection	**Deltoid**	**Deltoid**	**Deltoid**	**Deltoid**
Signature of Vaccine Administrator				

I want my child to receive the **required** vaccine(s) by State Law at the School Immunization Clinic and/or the **recommended** vaccines. Please circle **YES** or **NO** at the above vaccines.

Parent or **guardian** signature:____

Printed Name:____

Home or daytime phone number:(____)_______-__________

My child is Insured by: Private Insurance______, Medicaid/HMO_______. Or NO Insurance______.
We can administer the vaccines if your child does not have insurance.

YOU MUST:

- Fill out the Registration/permission form completely. **Do not forget your signature and clearly printed name.**
- **If you have insurance, (including Medicaid/HMO) that will cover vaccines and administration for your child we must have a copy of the insurance card(s).**
- **Copy your insurance card (both sides),** and be sure that the Policy holder/Insured's **Birthday** is written on the copy of the insurance card. **You may copy your card at the Hardy County Health Department M-F 8am-4pm and leave with staff,** or you can take a picture of both sides of the card (identify the child's name that is to receive the vaccine) and email to: donna.c.mongold@wv.gov
- **Please attach a copy of your insurance card or complete the following.**

Insurance Company Name:____

Insurance Company Address:______________________________________

Insured's Name:__________________________ Date of Birth:___________

Insured's Address: **(If different than the child):**____

Insurance **ID#**___________________________________

Insurance **Group#**_________________________