Granite County Public Health Department

212 E. Front Street ~ P.O. Box 312 ~ Drummond, MT 5932
Phone: 406-531-5443 ~ Fax: 406-288-0330

SCHOOL VACCINE FORM

Dear Parent/Guardian:
The Public Health Department has immunizations available on site for your student's convenience. Below is a list of required/ recommended immunizations. Please check which immunizations you would like your child to receive, if you are not sure if your student is up to date please call the school nurse or the public health department and they will assist you.

If Your Choice Is Not To Vaccinate-- Please Do Not Fill Out This Form.

CLIENT INFORMATION & CONSENT FOR VACCINE

Students Name: _____ Age: _____ DOB: _____
(PLEASE PRINT) (Last) (First) (MI)

Address: _____
(Street Address/P.O. Box #) (City/State) (Zip)

Telephone: _____ Student's Grade: _____
(Primary Phone) (Work)

Payment Choices: **Please supply a copy of front and back of card.** (Please check the box & circle or fill in the information):

- ○ Medicare/Medicaid/ Healthy Montana Kids ○ Uninsured: No insurance coverage **VFC** ___ **Private** ___
- ○ Private Insurance Company: Insured's Name: _____ Insured's Date of Birth: _____

Confidential client statistical information (Please check all that apply):

	Gender:		Ethnicity:		Race:				Primary Language:
○	Female	○	Yes, Hispanic Origin	○	White	○	Asian	○	English
○	Male	○	No, Not Hispanic Origin	○	Alaska Native	○	Black	○	Spanish
○	Other	○	Unknown	○	Native American	○	Pacific Islander	○	Other
					Other_____				

Health History:

Primary Physician: _____ Allergies: _____ I authorize the necessary vaccine services be provided by Granite County Public Health Department. I understand that these services are kept in strict confidence and that any transfer of these records requires my written authorization. I acknowledge that I am responsible for any outstanding balances.

I authorize electronic preservation of the vaccine records in the Montana State Registry. **Please Initial:** _____

Signature: _____ **Print Name:** _____ **Date:** _____
(Parent or Legal Guardian) Consent for Vaccination

IMMUNIZATIONS AVAILABLE:

○	DTaP- Diptheria, Tetanus, Pertussis **Required for School**	○	IPV- Polio **Required for School**	○	Flu-Influenza Injection	○	MCV-(Meningococcal Recommended at age 11)
○	Varicella-Chickenpox **Required for School**	○	MMR- Measles, Mumps, Rubella **Required for School**	○	Hep A- Hepatitis A recommended at age 1	○	Men B- Recommended for College Bound Seniors
○	Tdap Recommended at age 11 **Required for 7th Grade Entry.**	○	Covid 19- Pfizer – Recommended at 12 & older	○	HPV- (Human Papillomavirus Recommended at age 11)		

A. Information to determine if you should receive the flu vaccine	NO	YES
1. Do you have an allergy to Eggs?		
2. Do you have an allergy to gentamicin, neomycin, polymixin, or gelatin?		
3. Have you ever had a serious reaction to a flu vaccine in the past?		
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
5. Have you received any vaccine (not just flu) within the past 30 days? Vaccine: _____ *Date Given: month ____ day ____ year ____*		

Vaccine prices subject to change

Revised 7/31/2022