2024 ADOLESCENT VACCINATION CONSENT FORM

(Tdap, HPV, Meningococcal ACWY)

Name: _____
Last First Middle

Date of Birth: ____/____/____ Age: _____ Gender: ❑ M ❑ F

If minor - parent/guardian's name: _____
Last First M.I.

Parent/Guardian's Date of Birth: __/____/____ Parent's SSN: _____
Optional

Address: _____ City: _____ ZIP: _____

Grade: _____ Home Room Teacher: _____ School: _____

IMPORTANT Parent/Guardian Phone # Home: _____ Cell: _____ Work: _____

Emergency Contact:_____ Emergency contact number:_____
(If other than Head of Household)

Health Department Use Only

Cli ID #: _____

Encounter #: _____

My child will be 11 years of age or older on the day of the scheduled vaccination clinic: YES □ NO □

Please check YES or NO to all the questions below to determine if your child can receive offered vaccines at school. The nurse giving the vaccine will review this information on the day of the vaccine clinic.

	YES	NO
Has your child ever had a serious allergic reaction to any vaccine component or yeast?	❑	❑
Has your child ever had a serious reaction to a previous dose of Tdap, HPV, or Meningococcal vaccine in the past?	❑	❑
Did your child experience a coma, decreased level of consciousness, or long or multiple seizures within seven days following a dose of DTP, DTaP or Tdap?	❑	❑
Does your child have seizures or another nervous system problem; ever had severe swelling or severe pain after a previous dose of DTP, DTaP, DT, or Td; or ever had Guillain-Barré Syndrome (GBS)? If so, consult your doctor about receiving Tdap vaccine. (A note may be required to proceed in school setting)	❑	❑
Is your child pregnant? If yes, your child will not receive the HPV vaccine, but may receive the other vaccines.	❑	❑

If you answered YES to questions, this vaccine(s) may not be safe for your child and s/he WILL NOT receive these vaccines at school. If your child has a severe life-threatening allergy, please speak with your child's doctor before consenting to vaccination.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:
1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids in a way that may transmit disease, I understand that the law requires my child to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. 2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

*** Insurance*:** Please answer the following: This information is required for federal funding purposes for VFC vaccines.

***Note**: Vaccines will be provided to your child without cost to you if your child is eligible for the Vaccines for Children Program. If your child is covered by a private health insurance plan, the Department shall seek reimbursement for all allowable costs associated with the provision of the vaccine. **Your child will not be vaccinated if you do not provide all requested insurance information below.**

My child:( ) is *not* insured (not covered by private insurance, Medicaid, Medicaid MCO or FAMIS)
( ) is American Indian or is an Alaska Native
( ) has Medicaid MCO with: Sentara Community Care, Anthem Healthkeepers Plus, Molina Healthcare, United Healthcare Community Plan, or Aetna Better Health (circle your plan)
Member ID # as shown on your card: _____ is this a FAMIS plan? ❑Y ❑N
( ) has Medicaid or FAMIS (circle one) that is not a MCO plan: Medicaid # _____
( ) has other insurance not listed above (specify plan name) _____
Policy ID # _____ Policy holder's name _____
Attach a copy of the front & back of insurance card or provide the following information:
Insurance company address _____
Insurance company phone number _____

I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third-party payer to pay any authorized benefits to VDH on my behalf.

Office of Privacy and Security

Authorization for Disclosure of Protected Health Information

This consent gives the Virginia Department of Health (VDH) permission to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to my child cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that immunization records of my child will be retained for 21 years after birth.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

❑ Please check box if you wish to receive a copy of the Virginia Department of Health Notice of Privacy Practices.

CONSENT FOR CHILD'S HPV VACCINATION:

☐ My child has NEVER been vaccinated for HPV. **Note: Your child will require two doses: the first dose now and the 2nd Dose 6 months after Dose 1. NOTE: children with certain medical conditions may require three doses. Please consult your provider to assess the need for a third dose.**

☐ My child has received the first dose of the HPV vaccine. **Note: the 2nd Dose should be received 6 months after Dose 1.**

I have read the 2021 Vaccination Information Statement (VIS) for the HPV Vaccine. I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the HPV vaccine (shot) **If needed, I give my consent for my child to receive the second dose approximately six months after the first dose.**

Signature of Parent or Legal Guardian: X _____Date: ____/_____/____

CONSENT FOR CHILD'S MenACWY VACCINATION:

I have read the 2021 Vaccination Information Statement (VIS) for the MenACWY Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the Meningococcal ACWY vaccine (shot**).**

Signature of Parent or Legal Guardian: X _____Date: ____/_____/____

CONSENT FOR CHILD'S Tdap VACCINATION:

I have read the 2021 Vaccination Information Statement (VIS) for the Tdap Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the Tdap vaccine (shot**).**

Signature of Parent or Legal Guardian: X _____Date: ____/_____/____

Please send a copy of my child's immunization record to her/his doctor at the following address.

*Doctor's Name*_____*Mailing Address*_____*City*_____ *State*_____*ZIP*_____

HEALTH DEPARTMENT USE ONLY					
Date	**Item code**	**Fund Source**	**Lot Number**	**Vaccine Administration Site**	**Provider #**
	Tdap	**VFC STF**		**RA LA**	
	MenACWY	**VFC STF**		**RA LA**	
	HPV #1	**VFC STF**		**RA LA**	
	HPV #2	**VFC STF**		**RA LA**	
		VFC STF		**RA LA**	
Comments					
Provider Name/Signature and Date					