Cloverleaf

The Ohio Department of Health has additional **Tdap** and **Meningitis** vaccine requirements for students entering 7th and 12th grade for the 2018-2019 school year. The Medina County Health Department, in partnership with Cloverleaf Schools, is making it convenient and affordable for your children to receive adolescent vaccines and meet the new requirements.

Vaccine Clinic
Thursday
March 22, 2018
3:00 - 5:00 p.m.
Cloverleaf Middle School

Save Time!
Call ahead, have us register your child and obtain any insurance info. To register, call 330-723-9688, option 2

The following forms of payment are accepted

We accept cash, check, credit cards, Medicaid and many commercial insurance plans.
No child will be denied service due to inability to pay.

Aetna
Buckeye Health Plan
Caresource Marketplace
Medicare SSDI
Molina Health Care
SummaCare-Private (some plans)
Anthem/Blue Cross Private
Caresource
Cigna
Medical Mutual
Paramount Advantage
UnitedHealthCare Community/Private Plans

Each child must be accompanied by a parent or legal guardian with a photo ID. Please bring your child's most current immunization record and their insurance cards(s).

MEDINA COUNTY HEALTH DEPARTMENT

Medina County Health Department Community Health Division **Administration of Tdap, Meningitis, Meng. Serogp B, or HPV Vaccine** **SPRING 2018**

CONSENT FORM **STUDENT**

Section 1: Information about Child to Receive Vaccine (please print using black ink)

STUDENT'S NAME (Last)		(First)	(M.I.)	**STUDENT'S DOB**	**RACE:**
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	**STUDENT'S AGE**	**GENDER M / F**
ADDRESS:		COUNTY:		☐ **Hispanic** ☐ **Non-Hispanic**	**PHYSICIAN:**
CITY:	TOWNSHIP	STATE:	ZIP:	**SCHOOL NAME**	**DENTIST:**
PARENT/GDN DAYTIME PH ( )	STUDENT SOCIAL SECURITY	PARENT/GUARDIAN EMAIL			

Please complete this information for the following insurance plans:

Aetna, Anthem/Blue Cross Private, Buckeye Health Plan, Caresource, Caresource Marketplace, Cigna, Medicare SSDI, Medical Mutual, Molina Health Care, Paramount Advantage, Summacare-Private (some plans), UnitedHealthCare Community/Private Plans

Primary Insurance Company: _____ **ID Number:** _____

Relationship to insured: ☐ **Child** ☐ **Self** ☐ **Spouse** ☐ **Other** **Group Number:** _____

Insurance Holder's Name: _____ **DOB:** _____ **Sex:** _____

Social Security Number: _____ **Street:** _____

If different than patient address **Phone:** _____ **City, State Zip:** _____

Secondary Insurance Company: _____ **ID Number:** _____

1.	Is your child currently well? If more than mildly ill on vaccination day, keep child home.	Yes ☐ No ☐
2.	Does your child have any allergies to any foods, medications, or vaccines? Please list:	Yes ☐ No ☐
3.	Has your child had problems after previous immunization?	Yes ☐ No ☐
4.	Has your child had seizures, brain, or other nervous system problems?	Yes ☐ No ☐
5.	Has your child ever had Guillain- Barré Syndrome (a type of severe muscle weakness) within 6 weeks after receiving an immunization?	Yes ☐ No ☐
6.	Is your child without health insurance coverage?	Yes ☐ No ☐
7.	Is your child a Native American or Alaskan Native?	Yes ☐ No ☐
8.	Does your child's health insurance cover vaccinations?	Yes ☐ No ☐
9.	Has the annual maximum amount of vaccine coverage for this child been met this year?	Yes ☐ No ☐

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government health benefits to the Medina County Health Department, who accepts assignment. I have read or been given a copy of the Medina County Health Department's Notice of Privacy Practices and have been given the opportunity to have any questions answered. I have been advised that a 15-minute waiting period after vaccination is recommended to observe for fainting episodes that can sometimes occur.

Consent for Vaccine Administration

I have truthfully answered all of the questions on this form. I have also received a copy of the current Vaccine Information Statement (VIS) for the adolescent vaccine (s) my child is receiving today. I have had the opportunity to ask questions and fully understand the benefits and risks of this/these vaccination (s). My signature below indicates my permission for vaccine administration.

_____ _____ _____

Printed Name of Parent / Guardian / Patient **Signature** of Parent / Guardian / Patient Date

_____ _____

Signature of RN completing assessment Date