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**Teen Vaccination**

**Patient Information**

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| --- |
| **Patient’s Legal Name:** |
| **Parent/Guardian Name** (if pt under 18): |
| **Patient’s Date of Birth:** | **Age:** | **Gender:** |
| **Mailing Address:** |
| **Phone:**  | Home: | Cell: |

**Patient Insurance Information**

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| **Select most appropriate form of insurance:** |
| **None:**  | **Healthy MT Kids (Medicaid):**  | **BlueCross BlueShield Health MT Kids:**  | **Private:**  |
| **Insurance Info:** | Name of Insurance:  |
| ID: | Group: |
| **Subscriber Info:** | Name: | DOB: |
| Relationship to patient: | Employer: |

**Immunization(s) Requested**

|  |
| --- |
| Please circle Yes or No to indicate desired vaccine(s) |
| **Tdap**Yes No | **Meningococcal**Yes No | **HPV**Yes No | **Hepatitis A**Yes No |

**Health Information**

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| The following questions will help us determine which vaccines your child may be given today. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it. |
|  | Yes | No | Don’t Know |
| 1.  | Is the child sick today? |  |  |  |
| 2.  | Does the child have allergies to medications, food, latex or any vaccine? |  |  |  |
| 3.  | Has the child had a serious reaction to a vaccine in the past? |  |  |  |
| 4.  | Has the child, a sibling or a parent had a seizure; has the child had brain or other nervous system problems?  |  |  |  |
| 5.  | Is the child pregnant or is there a change she could become pregnant during the next month? |  |  |  |

**Acknowledgement and Consent**

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| --- | --- |
|  | **Initials** |
| I have read or have had explained to me the information contained in the Vaccine Information Statement about the disease and the vaccine. I have had a chance to ask questions which were answered to my satisfaction |  |
| I understand the benefits and risks of the vaccine and request the vaccine to the person named above for whom I am authorized to make this request |  |
| I have received, if requested, the Notice of Privacy Practices, which provides a description of information, uses and disclosures |  |
| I consent to the shared use of demographic information and authorize my immunization records to be recorded into the State of Montana Immunization Registry for immunization health purposes and that it may be released to health care providers, child care providers and schools across the state that may provide continuing immunization services. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department |  |
| I authorize payment of medical benefits to this county health department for services rendered. I understand that the patient/parent or responsible party is responsible for any unpaid balances |  |

**Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Department Section Only**

|  |  |  |  |
| --- | --- | --- | --- |
| School:  | Alberton  | St. Regis | Superior |
| Form reviewed by: | Date:  |
|  |
| Vaccine Type: **Tdap** | Manufacturer: |
| Lot Number | Injection Site: |
| VIS Date: | Signature/title administrator: |
|  |
| Vaccine Type: **MCV4** | Manufacturer: |
| Lot Number | Injection Site: |
| VIS Date: | Signature/title administrator: |
|  |
| Vaccine Type: **HPV** | Manufacturer: |
| Lot Number | Injection Site: |
| VIS Date: | Signature/title administrator: |
|  |
| Vaccine Type: **Hep A** | Manufacturer: |
| Lot Number | Injection Site: |
| VIS Date: | Signature/title administrator: |

**Notes:**

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