Monroe County Health Department
118 Home Avenue
Woodsfield, Ohio 43793
740-472-1677 Ext 3

6th Grade in School Consent Form

COMPLETE ALL FIELDS (Required for YES or NO consent)

Student Name (Last)	**(First)**	**(M.I.)**	**Date of Birth**	**Age**	**Grade**

School	**Circle one** **Male Female**

Parent/Guardian Name (Last)	**(First)**	**Parent/Guardian Phone number (Please provide 2 contact numbers)**

Address			**1.**

City	**State**	**Zip**	**2.**

I have read or had explained to me the Meningitis & Tdap and (HPV and Hepatitis A if chosen) Vaccine Information Statement and understand the risks and benefits. I grant permission for this record to be released to public health authorities for entry into the statewide immunization registry called IMPACT SIIS.

Insurance Information (Please attach a copy of your insurance card)

***Please Circle Payer/Insurance that patient is covered by*:**

CareSource ☐ *Molina* ☐ *UnitedHealthcare* ☐ *Buckeye Health Plan* ☐ *Private Insurance* ☐ *Private Pay* ☐

We can only bill the insurance companies on the sheet provided. We are more than willing to vaccinate children on other insurance plans but these would have to be private pay.

Complete the following with the information from your health insurance card:

Insurance Name: _____

Member ID #: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Employer: _____ Insurance Effective Date: _____

Required:

☐ **I CONSENT** to the Monroe County Health Department to administer **Meningitis** vaccine to my child.

☐ **I CONSENT** to the Monroe County Health Department to administer **Tdap** vaccine to my child.

Optional:

☐ **I CONSENT** to the Monroe County Health Department to administer **HPV** vaccine to my child.

I CONSENT to the Monroe County Health Department to administer vaccines as checked above. I give permission to the Monroe County Health Department to bill my insurance and I accept the responsibility for my balances, co-pays or deductibles. If I am self-pay, I will be responsible for the fee charged for each vaccination given. (REV. 08/2023)

Signature of Parent/guardian_____ Date_____

☐ **I DO *NOT* CONSENT** to the Monroe County Health Department to vaccinate my child at this time.

Signature of Parent/guardian_____Date_____

REVISED 8/23

For Office Use Only

- ✓ Are you sick today? Yes No Don't Know

Payment information

( )VFC/Child Medicaid ( )Vaxcare/Adult Medicaid ( )Self Pay $_____Check#_____/Cash

Nurse Signature: _____ Date:_____

CPT	Vaccine	Route	LOT # / Manufacturer / Trade Name	Site LD/RD
90734	Meningitis	IM		
90715	Tdap	IM		
90651	HPV	IM		
99211	Nurse-Minimal Visit/Office			
90460	Admin of Vaccine (Child)			
90471	1st Vaccine Admin Adults/Ins			
90472	>2 Vaccine Admin Adults/Ins			

REVISED 8/23