School Tdap

BUNCOMBE COUNTY DEPARTMENT OF HEALTH
2013 IMM CONSENT FORM

Office Use Only M&M Pt. #					

PLEASE PRINT

Child's LAST Name _____ Middle Initial _____

Child's FIRST Name _____ TEACHER _____

Mailing Address _____

City _____ State _____ ZIP _____

County _____ SSN _____ -- _____ -- _____

Birth Date _____ -- _____ -- _____ Age _____ phone _____ _____ _____

Sex: ☐ Male ☐ Female **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

- **Main Language Spoken:** _____
- **Race:** ☐ White ☐ African/American ☐ Native American/Alaskan ☐ Asian ☐ Pacific Island/Native Hawaiian
-

Please answer the following question. Note: This information is required for federal funding purposes. ***It will not prevent your child from receiving vaccines through this program. This information about your child will not be shared with anyone.***

My Child:

☐ Has Medicaid or Health Choice Coverage – Recipient I.D. Number_____

☐ Has no Insurance – No Medical Coverage

☐ Has Insurance - Name of Insurance Company: _____

Please **attach a COPY – FRONT and BACK of insurance card**..

Has your child ever fainted from having an injection?	☐ Yes	☐ No
Has your child ever had a serious reaction after receiving a vaccination?	☐ Yes	☐ No
Does your child have any allergies to medications, food, or any other vaccine? If yes please list: _____	☐ Yes	☐ No
Has your child had a seizure, brain, or other nervous system problem?	☐ Yes	☐ No

- **YES**, I give my permission for my child _____ to receive **Tetanus-diphtheria-pertussis (Tdap)($51)** (single dose)
- Private insurance and/or Medicaid will be billed for the cost of the vaccine and administration fee.
- I understand and accept responsibility for any services not covered by insurance or applied towards my deductible.
- I have read the Vaccination Information Statement for Tetanus-diphtheria-pertussis (Tdap) and understand the benefits, risks, and possible complications that can occur after receiving the vaccine. I agree that my child named above, does not have any of the conditions listed and have had my questions answered satisfactorily.
- I acknowledge that a copy of the Buncombe County Department of Health Notice of Privacy Practices *are* available to me *at*. http://buncombecounty.org/common/health/NoticeOfPrivacyPractices_English.pdf or at the school.

Authorized Person's Signature X _____ **Date** _____

STAFF USE ONLY - VACCINE ELIGIBILITY - - VACCINE DATA - - NURSE'S SIGNATURE

Tdap	Date:	Type of Vaccine: Tdap	Route: IM ☐ RD ☐LD	Pay Source ☐ State ☐County	Lot #:_____
Nurse's Signature_____		Nurse's M&M Initials_____		DATA ENTRY: Date / Initials	M&M _____/_____ NCIR _____/_____