TDAP / MENINGOCOCCAL / HPV VACCINATION CONSENT FORM

CHILD'S PERSONAL INFORMATION: (PLEASE PRINT)

LAST ____________________ FIRST ____________________ M.I.____ GENDER __________

BIRTHDAY ________________ AGE ______ EMAIL ADDRESS: ____________________________

ADDRESS ____________________________ CITY __________ ZIP CODE ______________

HOME PHONE # ________________________ ALTERNATE PHONE # ______________________

PARENT / GUARDIAN__________________________ PHYSICIAN ___________________________

DATE OF ATHLETIC PHYSICAL: ________________

Healthcare Coverage
MUST MARK ONE

☐ **Insurance plan (*includes HAWK-I*) that covers the selected vaccines:**

Insurance Company Name: ______________________________

Policy #: ______________________________________

Group #: ______________________________________

☐ **Covered by a Managed Care Organization (*Medicaid*):**

Insurance Company Name: ______________________________

Policy #: ______________________________________

Group #: ______________________________________

☐ **Insurance plan that DOES NOT cover the selected vaccines.**

☐ **No health insurance.**

Y OR N DOES YOUR CHILD HAVE ALLERGIES TO MEDICATION, FOOD OR ANY VACCINE COMPONENT? IF YES, EXPLAIN.

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Y OR N HAS YOUR CHILD HAD A SERIOUS REACTION TO A VACCINE IN THE PAST?

Y OR N HAS YOUR CHILD HAD A SEIZURE, BRAIN, OR OTHER NERVOUS SYSTEM PROBLEM?

Y OR N FOR FEMALES: IS YOUR DAUGHTER PREGNANT?

Y OR N I WOULD LIKE MY CHILD TO RECEIVE THE **TDAP** VACCINE.

Y OR N I WOULD LIKE MY CHILD TO RECEIVE THE **MENINGOCOCCAL(A,C,W,Y)** VACCINE.

Y OR N I WOULD LIKE MY CHILD TO RECEIVE **HPV-9** VACCINE-**DOSE #1**

I HAVE BEEN GIVEN ACCESS TO THE VACCINE INFORMATION STATEMENTS FOR TDAP (2-24-15), MENINGOCOCCAL (3-31-16) AND HPV-9 (12-2-16). I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS REGARDING THE VACCINES AND UNDERSTAND THE RISKS AND BENEFITS. I ALSO UNDERSTAND THE RISKS OF THE DISEASES THESE VACCINES PREVENT. TO MY KNOWLEDGE, MY CHILD HAS NO CONDITIONS THAT ARE CONTRAINDICATIONS FOR VACCINATION. CONSENT FORM IS VALID 1 MONTH FROM DATE OF INITIAL SIGNATURE. I PERMIT MY CHILD TO RECEIVE THESE VACCINES AT AVERA MEDICAL GROUP-SPENCER. I AM THE PARENT OR LEGAL GUARDIAN OF THIS CHILD.

SIGNATURE OF PARENT / GUARDIAN ______________________________ **DATE** ______________

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