2020 High School Vaccination Program

PLEASE COMPLETE AND RETURN THIS FORM BY January 15TH

(Unreadable and incomplete forms may not be accepted.)

Full, Legal Name of Student *(First Name Middle Initial. Last Name)* **PLEASE PRINT**	**Name of School**
Parent/Guardian Name *(First Name Middle Initial. Last Name)* **Relationship to Student**	**Homeroom Teacher** **Grade**
Street Address **Email Address**	**Birth Date (month/date/year)** **Age** **Sex**
City: **Zip Code**	**Home Phone #** **Cell Phone #**

Demographic Information: (Circle one) White American Indian/Native Alaskan Black Asian Hispanic Other

☐ **INSURANCE** ☐ **MEDICAID (Prestige, UHC Community, StayWell/Wellcare, & Sunshine)** ☐ **MY CHILD DOES NOT HAVE HEALTH INSURANCE**

The current health care laws require us to bill your insurance company for the vaccine. You will not be billed, and there will be no co-pay or deductible due. The service is offered at no cost to you! As always, answers are confidential. Please fill out the following questions regarding your child's health insurance plan:

Insurance Company:	Member ID:
Policy Holder's Name:	Policy Holder's Date of Birth:

HEALTH QUESTION: ***(If you answer YES, your child cannot receive any of the vaccines unless approved by your child's health care provider)***

Yes	No	1. Do any of the following apply to your child?	
☐	☐	• Severe allergy to yeast or latex • Severe life-threatening allergies • Severe reaction to previous dose from any of the Vaccines • Moderately or severely ill	• Has had Guillain-Barre syndrome (very rare) • Pregnant, will be pregnant in the next six (6) months, or is currently breastfeeding.

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S HEALTH CARE PROVIDER OR CALL THE ALACHUA COUNTY HEALTH DEPARTMENT IMMUNIZATION CLINIC AT 352-334-7950.

If your child has any long-term health problems with weakened immune system, heart disease, lung disease (e.g. cystic fibrosis), liver disease, kidney disease, or metabolic disorders (e.g. diabetes) or blood disorders (e.g. sickle disease or thalassemia), please see your health care provider for Human Papillomavirus, Hepatitis A, Serogroup Meningococcal B and Meningococcal ACWY vaccine.

I have received, read, and understand the CDC Vaccine Information Statement for the Human Papillomavirus, Hepatitis A, Serogroup Meningococcal B and Meningococcal ACWY vaccine and the Notice of Privacy Practices. I have read these documents and understand the risk and benefits of the Human Papillomavirus, Hepatitis A, Serogroup Meningococcal B and Meningococcal ACWY vaccine. I give permission to the State of Florida, Department of Health to give my child the first and second dose (if needed) of the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Florida Department of Health policies, to assure optimal healthcare for my child.

☐ **YES, I Give Consent For My Child To Receive Meningoccocal B (MenB) vaccination.**

In addition, I give consent for my child to receive the following catchup vaccinations: Check each vaccine your child is to receive.

☐ **Human Papillomavirus (HPV)** ☐ **Meningococcal ACWY (MenACWY)** ☐ **Hepatitis A (HepA)**

☐ NO, I do not want my child to receive any of the vaccines at school, because _____.
(Optional)

_____ Printed Name of Parent/Guardian

_____ Signature of Parent/Guardian

_____ Date

Please return to the school, FAX to (352) 334-7947, or EMAIL to; SLIV@flhealth.gov
(Please note that e-mailing may not be a secure method of communication)

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

HPV VIS: 10/30/2019 **HepA VIS: 07/20/2016** **MenB VIS: 08/15/2019** **MenACWY: 08/15/2019** Date Given: _____ Signature/Title _____	Vaccine Lot # & Expiration Date Labels
HPV VIS: 10/30/2019 **HepA VIS: 07/20/2016** **MenB VIS: 08/15/2019** **MenACWY:08/15/2019** Date Given: _____ Signature/Title _____	Vaccine Lot # & Expiration Date Labels

Notes: