Walsh County Health District
638 Cooper Ave, Suite 3 Grafton, ND 58237
Phone: 701-352-5139 Fax: 701-352-5074

Meningococcal Conjugate and Meningococcal Group B Vaccine Consent Form

Clinic Provider #41

Name of School:	Grade	Teacher:

Information collected on this form will be used to document authorization of receipt of vaccine(s) and may be shared through the North Dakota Immunization Information System (NDIIS) with other entities in accordance with North Dakota Century Code 23-01-05.3.

Print Child's Name (Last, First and Middle, required):		**Date of Birth:**		**Age:**	**Gender: (circle)** Male Female
Address (Street or PO Box):	**City:**	**State:**	**Zip Code:**		**County**:
Parent/Guardian Name:	**Relationship:**	**Primary Phone #:**			

Please check all that apply.
__Medicaid Eligible - Medicaid Number_____
__Community Health - ID Number _____
__Native American
__No Insurance
__Under-insured (my insurance doesn't pay for vaccines)
__Insured – Fill out Policy Holder information below.

PRIMARY POLICY HOLDER INFORMATION

Policy Holder
Name (Last, First, MI):_____ Policy Holder **Date of Birth:**_____

Gender: Male Female **Policy Holder Relationship to Child:** _____

Insurance Company Name :_____

Insurance Address:_____
(City) (State) (Zip)
Policy Number (ID Number) :_____ **Group Number and/or Payer ID if applicable:**_____

SECONDARY POLICY HOLDER INFORMATION (If child is covered under 2 insurances)

Policy Holder
Name (Last, First, MI):_____ Policy Holder **Date of Birth:**_____

Gender: Male Female **Policy Holder Relationship to Child:** _____

Insurance Company Name:_____

Insurance Address:_____
(City) (State) (Zip)
Policy Number (ID number):_____ **Group Number and/or Payer ID if applicable:**_____

Please answer the questions on the back, sign and date form.

Please circle a response for the person receiving the vaccine.		
Yes	No	Is the child to be vaccinated sick today?
Yes	No	Does the child to be vaccinated have any allergies to a vaccine component or to latex?
Yes	No	Has the child to be vaccinated ever had a serious reaction to any vaccine in the past?
Yes	No	Has the child to be vaccinated ever had Guillain-Barré syndrome?
Yes	No	Health problems (lung, heart, kidney, diabetes, asthma, or blood disorder? Long term aspirin therapy?
Yes	No	Child, sibling, or parent had a seizure? Child had brain or nervous system problem?
Yes	No	Have cancer, leukemia, HIV/AIDS, or any immune system problem?
Yes	No	In past 3 months, taken medications that affect immune system (prednisone, steroids, anticancer drugs, drugs for rheumatoid arthritis, Crohn's disease, or psoriasis? Had radiation treatments?
Yes	No	In past year, received a blood transfusion or given immune (gamma) globulin or antiviral drug?
Yes	No	For females: Is your child pregnant?
Yes	No	Received vaccinations in the past 4 weeks? MMR, Chickenpox, or live flu vaccine?
Yes	No	Is the child exposed to second-hand smoke?
Yes	No	If 13 years or older, does child use tobacco? (ex. Smoke, Chew, E-cigarettes, other)

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

Revised 4/10/2015

A Copy of the **Vaccine Information Statement(s) has been provided.** I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed. I had an opportunity to ask questions and believe that I understand the benefits and risks of the vaccine(s) cited. **I consent to the administration of the vaccine(s) listed to be given to the person named above and I am authorizing to give this consent.** Information collected on this form will be used to document receipt of vaccine(s) and **I consent to the exchange of this information** with the ND Immunization Information System (NDIIS) and other entities in accordance with ND Century Code 23-01-05.3.

Walsh County Health District's (WCHD) Notice of **Privacy Practice** is available online or by request.

I agree to pay and I am financially responsible for WCHD's established charges provided to the Client not covered by a third-party payer. I assign and **authorize any third party payer/insurer** to make direct payment to WCHD. *I authorize the release of information necessary to process this claim.*

X_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

BELOW FOR WCHD OFFICE USE ONLY.

Refused to answer question Advised to quit ☐ Cessation referral/education offered ☐

√	Vaccine(s) To Be Given	Lot Number	Mfr	VIS Date	Rte	Admin Site (circle one)
	Meningococcal Conjugate (MCV4)		SP	8/9/16	IM	LA RA

Vaccine Administrator: **Date Administered:**

√	Vaccine(s) To Be Given	Lot Number	Mfr	VIS Date	Rte	Admin Site (circle one)
	Meningococcal Group B (MenB)		SP	3/31/16	IM	LA RA

Vaccine Administrator: **Date Administered:**

√	Vaccine(s) To Be Given	Lot Number	Mfr	VIS Date	Rte	Admin Site (circle one)
	2nd Meningococcal Group B (MenB)		SP	3/31/16	IM	LA RA

Vaccine Administrator: **Date Administered:**

Route: IM= Intramuscular, , Site: LA= Left Arm, RA= Right Arm
Manufacturer: SP= Sanofi Pasteur (Aventis); GSK = GlaxoSmithKline