NOBLE COUNTY HEALTH DEPARTMENT
EAST NOBLE MIDDLE SCHOOL

WHO: Any Middle School student needing vaccines
WHAT: School shot clinic for state required and recommended immunizations
WHEN: September 16th, 2026
WHERE: East Noble Middle School
WHY: To meet requirements for the state of Indiana for the 2026/2027 school year

Routine Vaccines for Grade 6-8:

MENINGOCOCCAL ACWY

TDAP

HPV/HUMAN PAPILLOMAVIRUS

Other School Required Vaccines Available if child is behind:

HEPATITIS B

POLIO

VARICELLA

HEPATITIS A

MMR/MEASLES, MUMPS, AND RUBELLA

*** Please note on the consent form which vaccines you consent to***

COST: FREE to all students with Medicaid, no health insurance, or health insurance that does not cover the cost of immunizations. Students with private health insurance will have the cost of the immunizations billed to their insurance company. **You will be responsible for payment for the vaccines provided if your insurance provider applies the cost to your deductible (may occur with some Signature Care and PHP plans). Payment must be arranged prior to vaccination if your deductible has not been met.**

By federal law, children who have private insurance that covers the cost of vaccines (as preventative care or after deductibles) can only be given privately purchased vaccine. The health department utilizes a third party company (VaxCare) to bill most insurances. If the health department is unable to determine eligibility through VaxCare, payment upfront is required prior to vaccination.

IMMUNIZATION DATA REGISTRY AND EXCLUSION

COUNTERMEASURES INJURY COMPENSATION PROGRAM

School Clinic Routine Vaccine Consent Form

Please return this form completed and signed to the school in order for your student to receive their vaccinations at the school clinic.

Student Information			
Last name:		First Name:	
Address:		City:	Zip Code:
Date of Birth: Month:	Day:	Year:	Age:
Gender:	School:		Grade:
Parent/Guardian Name:		Phone #:	

Health Insurance Information

Please fill out section #1 if the student has private insurance, section #2 if the student has Medicaid or section #3 if the student has no insurance or insurance does not cover vaccines.

Section # 1:	Section # 2:	Section # 3:
Insurance Company:		
Member ID:	Medicaid ID #:	Check if No Insurance:
Group # (if applicable)		
Name of Insurance Holder:	_____	☐
Date of Birth of Insurance Holder:		

**By signing below, I request that payment of Medicaid benefits be made on my behalf to Noble County Health Department for any services provided to my child. I give Noble County Health Department permission to exchange my child's medical or other confidential information as necessary to the centers for Medicare and Medicaid Services (CMS) its agents, or other agents needed to determine benefits related to services provided. I agree to participate in treatment plans and to assignment of Medicaid benefits to Noble County Health Department for services rendered.*

**By signing below, I consent to the use and disclosure of my child's personal health information for the purpose of health care operations along with the assignment of all payments from the insurer listed above to VaxCare for the services rendered. I understand that I will be responsible for payment for the vaccines if my insurance company does not pay.*

Vaccine Health Screening		
1. Does the student have any allergies to medication, foods, or any vaccines? *If yes, please explain*: _____	**Yes**	**No**
2. Has the student had a serious reaction to a vaccine in the past? *If yes, please explain & list vaccine*: _____	**Yes**	**No**
3. Has the student had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (diabetes) or a blood disorder? *If yes, please explain*: _____	**Yes**	**No**
4. Has the student, a sibling, or a parent had a seizure, brain or other nervous system problem, including Guillain-Barre Syndrome? *If yes, please explain & list problem*: _____	**Yes**	**No**
5. Does the student have cancer, leukemia, AIDS, active tuberculosis or any other immune system problems? *If yes, please explain*: _____	**Yes**	**No**
6. Has the student taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months? *If yes, please explain*: _____	**Yes**	**No**
7. Has the student received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?	**Yes**	**No**
8. Is the student pregnant or is there a chance she could become pregnant during the next month?	**Yes**	**No**
9. Has the student received any vaccinations in the past four (4) weeks?	**Yes**	**No**
10. Has the student ever felt dizzy or faint before, during or after a shot?	**Yes**	**No**
Notes to Nurse:		

PLEASE TURN OVER TO COMPLETE FORM ->

Student's Name: _____

Informed Consent

The Health Department will review your child's vaccination history and vaccinate only if your child requires it.

Check each of the vaccines you consent to your child receiving:

***** Please note, even if checked, if your child does not need it based on their record, they will NOT receive that vaccine*****

- ☐ Meningococcal ACWY (MCV4)
- ☐ Tdap
- ☐ Human Papilloma Virus (HPV)
- ☐ Hepatitis B
- ☐ Polio
- ☐ MMR/ Measles,Mumps,Rubella
- ☐ Hepatitis A
- ☐ Varicella/ Chicken Pox

Authorization and Consent

Consent for use of Protected Health Information and Claims Assignment: I hereby consent to and acknowledge the receipt of a Notice Privacy Practices regarding the use and disclosure of my personal health information for the purpose of healthcare operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein. Vaccine authorization: My signature on this form indicated that I have requested that the vaccine indicated below be administered to me by VaxStation or VaxCare representative. I relieve VaxCare, the VaxCare partner, the administering Nurse and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out of or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association. Neither I or VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities, or arbitrate any claims as a representative member of a class or in a private attorney general capacity. In the case of occupational exposure, VaxCare has patient's permission for blood testing for patient and employee safety alike. I have read or have had explained to me the information from the Vaccine Information Statement(s) and understand the risks (including adverse reactions) and benefits of the vaccine(s). I understand I will be responsible for payment for the below vaccine(s), these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. Additionally, I understand that if I am a self-pay or no-pay patient receiving services that all funds should be paid at the time of service and not remit to VaxCare. If consenting for another: I have legal authority, based on my relationship to the individual indicated above, to consent to this vaccine(s) administration.

Signature of Parent/Legal Guardian: _____ **Date:** _____

CDC Vaccine Information Sheets:

Immunization Data Registry and Exclusion:

Countermeasures Injury Compensation Program:

Vaccine Administrator: _____ Date: _____