VACCINE REGISTRATION – SCHOOL-BASED CLINICS – TEEN VACCINES

What will your child's school grade be in Fall 2026? (circle answer) **7th grade** **12th grade**

PATIENT NAME: _____ **DATE OF BIRTH**_____**AGE**_____

ADDRESS: STREET_____ **CITY**_____ **ZIP CODE**_____

PHONE ( ) _____ **MALE or FEMALE (circle one)** **Approx. Weight** _____

IF PATIENT IS UNDER AGE 18:
Name of Parent of Legal Guardian: (please print) _____ **Relationship:** _____

Phone number parent/legal guardian can be reached DURING THE VACCINE CLINIC: _____

INSURANCE INFORMATION: ***PLEASE ATTACH COPY OF INSURANCE CARD (or email it to school nurse)***
Does the Patient Have Insurance or a Medical Card? (circle answer) **YES NO**

If Yes: Insurance Company Name: _____ **ID or Policy #:** _____

Patient's SSN: _____

Consent for assignment of benefits: If your child has insurance, the Scioto County Health Department is authorized to bill your insurance company for the cost of the vaccine (if private insurance) and for an administration fee (if a Medicaid or private insurance) to help us cover the cost of our clinics. If you have private insurance and your insurance company does not pay the cost of the vaccine, you will be billed fo the cost of the vaccine ($80 for Tdap, $205 for a Meningococcal, $360 for HPV, $65 for Hep A, and $280 for Men B vaccine). If your child has Medicaid, you will not be billed. **I consent for the Scioto County Health Department to bill my insurance company for the vaccine anc administration fee.**

Signature of parent/legal guardian (or patient if 18 or over) : _____ **Date**_____

PLEASE CHECK ALL VACCINES YOU WANT YOUR CHILD TO HAVE:

REQUIRED for school:

_____ Tdap (7th grade)

_____ Meningococcal (7th AND 12th grade)

RECOMMENDED:

_____ HPV (2 or 3 doses, depending on age)

_____ Hepatitis A (2 doses 6 months apart)

_____ Meningitis B (not contained in other Meningitis vaccine) (ages 16 or older; 2 doses 6 months apart)

WRITTEN REQUEST, CONSENT FOR VACCINE ADMINISTRATION, INFORMATION RELEASE, AND NOTICE OF PRIVACY PRACTICES:
The Scioto County Health Department's Notice of Privacy Practices is posted on the Scioto County Health Department's website http://www.sciotocountyhealth.com. The Vaccine Information Sheets (VIS) are available online at www.immunize.org as follows: Tdap https://www.immunize.org/vis/tdap.pdf , Meningococcal https://www.immunize.org/vis/meningococcal_acwy.pdf , Meningitis B https://www.immunize.org/vis/meningococcal_b.pdf ,Hepatitis A https://www.immunize.org/vis/hepatitis_a.pdf , HPV https://www.immunize.org/vis/hpv.pdf . If you are unable to access these documents online, would like us to provide you with a paper copy, or have questions about our privacy practices or the vaccine, please call 750-355-8358 (Nursing Division, option 2).
I hereby attest that I am the parent, legal custodian/guardian/medical POA of the above-named person who is a student at the _____ Local School District. I have read or had explained to me the Vaccine Information Statements about these vaccines as listed above, and the Scioto County Health Department's Notice of Privacy Practices. I understand the benefits and risks of the vaccine(s) and I have had a chance to ask questions about the vaccine(s) which were answered to my satisfaction. I hereby request and give consent to the Scioto County Health Department and its staff/employees/agents for the person named above to be vaccinated and give consent for the vaccine(s) checked above to be administered to said person for whom I am authorized to give this consent, even if I am not present when the vaccine(s) are administered. In consideration having the vaccine(s) administered to the person named above, I hereby release Scioto Count and the Scioto County Board of Health, its officials, employees, and agents, together with all persons assisting with any phase of this vaccin program, from all liability and responsibility for any loss or injury related to the vaccine(s) being administered. I further agree to indemnify and hold harmless said parties from all claims hereafter made by me or on behalf of the person named above by any person or entity or their heirs, executors, or assigns. I also grant permission for the immunization record of the person named above to be released to providers, health departments, schools, the state immunization registry, and others as necessary for public health purposes.

Signature of parent/legal guardian (or patient if 18 or over): _____ **Date**_____

IMPORTANT: PLEASE ANSWER ALL THE SCREENING QUESTIONS ON THE FOLLOWING PAGE. *(rev 2-24-2026)*

Screening Checklist for Contraindications to HPV, MenACWY, MenB, and Tdap Vaccines for Teens

YOUR NAME _____

DATE OF BIRTH ____/____/____ (month / day / year)

For parents/guardians: The following questions will help us determine if human papillomavirus (HPV), meningococcal conjugate (MenACWY), meningococcal serogroup B (MenB), and tetanus, diphtheria, and acellular pertussis (Tdap) vaccines may be given to your teen today. If you answer "yes" to any question, it does not necessarily mean your teen should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is your teen sick today?	☐	☐	☐
2. Does your teen have allergies to a vaccine component or to latex?	☐	☐	☐
3. Has your teen had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has your teen had a brain or other nervous system problem?	☐	☐	☐
5. Is your teen pregnant?	☐	☐	☐
6. Has your teen ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
7. Is your teen anxious about getting a shot?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your teen's immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your teen's vaccinations. If you don't have one, ask your healthcare provider to give you one with all of your teen's vaccinations on it. Keep it in a safe place and be sure your teen carries it every time he/she seeks medical care. Your teen will likely need this document to enter school or college, for employment, or for international travel.