ALLEN COUNTY
PUBLIC HEALTH
www.allencountypublichealth.org
Allen County Combined Health District

Dear Parent of Upcoming 7th Grade Student,

Next year's 7th graders will be required to receive a **Tetanus, diphtheria and pertussis vaccine (Tdap)** and a **Meningococcal vaccine (MCV4)** prior to the start of the school year. Students without proof of vaccination will be subject to exclusion from school.

Allen County Public Health nurses will be at Bluffton School on **August 9th, 2023** from 9 to 11 am to administer the Meningococcal and Tdap vaccines to meet your child's school requirement for next year.
We will also have the HPV vaccine available if you choose to have your child vaccinated against HPV. (See attached handout for additional information on the vaccines.)

If you choose to have your teen vaccinated at the clinic you will not need to be present, however we will require that you have the attached forms completed prior to the clinic. The forms are:

1) Signed copy of this letter with vaccines checked
2) Yellow consent form
3) Insurance Information form

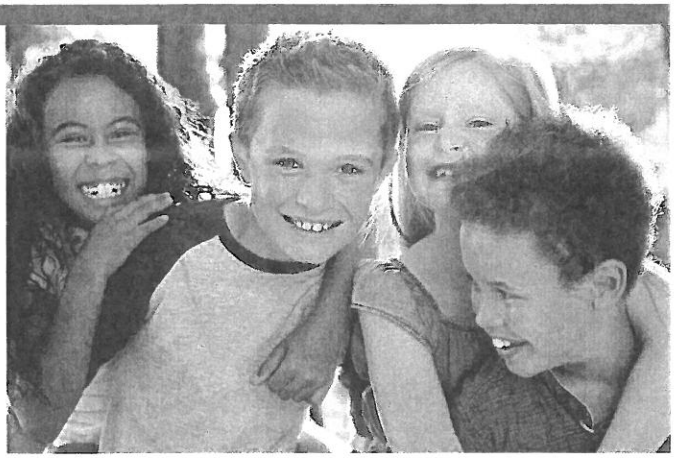
I choose to have my teen receive the following vaccines at Bluffton School Immunization Clinic. (Please check which vaccines you want your teen to receive).

Meningococcal (MCV4) Vaccine	_____	**(School requirement)**
Tdap vaccine	_____	(School Requirement)
HPV vaccine	_____	(Not required, but **highly** recommended

_____ _____
Parent/Guardian Signature Date

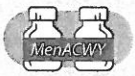
Lisa Horstman R.N.
Get Vaccinated Coordinator
Allen County Public Health

Vaccines for Preteens and Teens: What Parents Should Know



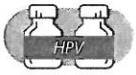
All boys and girls need three vaccines at ages 11-12 to protect against serious diseases. Preteens and teens should also get a yearly flu vaccine, as well as any vaccines they missed when they were younger.

What vaccines does my child need?



Dose 1: *Ages 11-12*
Dose 2: *Age 16*

Meningococcal vaccines protect against a type of bacteria that can cause serious illnesses. The two most common types of illnesses include infections of the lining of the brain and spinal cord (meningitis) and bloodstream. All preteens should get the meningococcal conjugate vaccine (MenACWY). Teens may also receive a serogroup B meningococcal vaccine (MenB), preferably at 16 through 18 years old.



Dose 1: *Ages 11-12*
Dose 2: *6-12 months later*

HPV vaccine protects both girls and boys from future infections that can lead to certain types of cancer. Children who get their first dose on or after their 15th birthday will need three doses.

Dose 1: *Ages 11-12*

Tdap vaccine protects against three serious diseases: tetanus, diphtheria, and pertussis (whooping cough).

Yearly Dose:
Ages 6 months and older

Flu vaccine helps protect against seasonal flu. Even healthy preteens and teens can get very sick from flu and spread it to others. The best time to get an annual flu vaccine is before flu begins causing illness in your community, ideally before the end of October. Flu vaccination is beneficial as long as flu viruses are circulating, even in January or later.

When should my child be vaccinated?

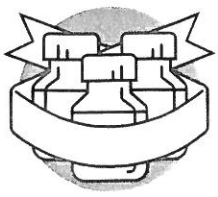
A good time to get these vaccines is during a yearly wellness check. Your child can also get these vaccines at a physical exam required for school, sports, or camp. **If your child missed any doses of recommended vaccines, ask your doctor or nurse about getting them now.**

Are these vaccines safe?

These vaccines have been studied very carefully and are very safe. They can cause mild side effects, like soreness or redness in the part of the arm where the shot is given. Some preteens or teens might faint after getting a shot. Sitting or lying down when getting a shot, and then for about 15 minutes after the shot, can help prevent fainting. Serious side effects are rare. It is very important to tell the doctor or nurse if your child has any serious allergies, including allergies to yeast, latex, or chicken eggs, before they receive any vaccines.

Can I get help paying for these vaccines?

Most health insurance plans cover routine vaccinations. The Vaccines for Children (VFC) program also provides vaccines for children 18 years and younger who are uninsured, underinsured, Medicaid-eligible, American Indian, or Alaska Native. Learn more at www.cdc.gov/Features/VFCprogram.



Talk to your child's doctor or nurse about the vaccines your child needs or visit **www.cdc.gov/vaccines/parents**

CDC

Last updated JULY 2019

ALLEN COUNTY PUBLIC HEALTH
"PLEASE PRINT"

Complete Information about person to receive vaccine **********"PLEASE PRINT"**********	DATE:	NEW CLIENT: YES__ NO____

Name: Last	First:	Middle Initial:	Date of Birth:	Age today:	
Mailing Address: Apt. #/Lot#	**City:**		**State:**	**Zip Code:**	**Township:**
Phone Number:		**Race:**	**Sex:** Male Female		
Social Security Number:		**Client's Doctor:**			
Parent or Legal Guardian's Name: **(for client under 18yrs. of age**					

PRE-VACCINE QUESTIONNAIRE

Has the person receiving shots today:	YES	NO
Been ill in the last 24 hours or had fever over 100 degrees In the last 24-48 hours?		
Had any problems with previous immunizations?		
Have any allergies to latex, food or medicine, including eggs or egg products, gelatin, streptomycin, neomycin or thimerosal (in contact lens solution)? If yes, list allergy here:		
Have any immune system problems such as cancer, leukemia, HIV/AIDS, or close contact with a person whose immune system is compromised?		
Taken any medications in the last 3 mo. that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs or had radiation treatments?		
Received blood products, transfusion, immune globulin, or antiviral drugs in the last year?		
Received any vaccines in the last 28 days?		
Pregnant or a chance of becoming pregnant in the next month?		
Or mother ever been diagnosed with Hepatitis B?		
Had a health problem with the lungs, heart, kidney or metabolic disease (e.g. diabetes, asthma, liver disease, sickle cell, or other blood disorders or on aspirin therapy?		
Have history of asthma, reactive airway disease or wheezing?		
Ever been diagnosed with Guillain-Barre Syndrome?		
Ever been told he or she has had intussusception?		
Or sibling or parent had a seizure, or other brain or nervous system disorder?		
Taken antibiotics or antiviral medications within the last 24 hours?		

Answer the following questions if pregnant or someone in your household is under age 4 years:

Are you currently on WIC?		
Would you like to be referred to WIC?		

I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the vaccine(s). I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s), and ask that the vaccine(s) be given to me, or the person named for whom I am authorized to make this statement.

I grant permission for this record to be released to the Ohio Dept. of Health, medical providers, health departments, schools, daycare centers and as the law requires.

Signature required of person to receive vaccine or person authorized to make the request. if client is less than 18 years of age:

Name: _____ **Date:** _____

*****STOP HERE!*****

STOP HERE! THIS SIDE TO BE FILLED OUT BY STAFF ONLY:

PATIENT ELIGIBILITY SCREENING RECORD (Vaccines for Children Program)

1. Is this Client enrolled in Medicaid? Yes_____ No_____
2. Does this client have Health Insurance? Yes_____ No_____
3. Is client an Alaskan native or A Native American Indian? Yes_____ No_____
4. VFC Qualified? Date_____ Yes_____ No_____
5. VIS Given? Yes_____ No_____

VACCINE	DATE GIVEN	MANUFACTURER	LOT NUMBER	INJECTION SITE	VIS DATE	ADMINISTERED BY:
Pediarix (IPV-Dtap-Hep B)	/ /			LT RT LD RD	10-15-2021	
Pentacel (IPV-Dtap-HIB)	/ /			LT RT LD RD	10-15-2021	
Vaxelis (IPV-Dtap-HIB-Hep B)	/ /			LT RT LD RD	10-15-2021	
IPV	/ /			LT RT LD RD	8-6-2021	
Kinrix (IPV-Dtap)	/ /			LT RT LD RD	8-6-2021	
Quadracel	/ /			LT RT LD RD	8-6-2021	
Dtap / DT	/ /			LT RT LD RD	8-6-2021	
Td / Tdap	/ /			LT RT LD RD	8-6-2021	
HIB	/ /			LT RT LD RD	8-6-2021	
HPV 9	/ /			LD RD	8-6-2021	
HEP-B	/ /			LT RT LD RD	10-15-2021	
HEP-A	/ /			LT RT LD RD	10-15-2021	
MMR	/ /			LA RA	8-6-2021	
VARICELLA	/ /			LA RA	8-6-2021	
Proquad (MMR-VAR)	/ /			LA RA	8-6-2021	
Rotovirus	/ /			O	10-15-2021	
Prevnar 13	/ /			LT RT LD RD	2-4-2022	
Prevnar 15	/ /			LT RT LD RD	2-4-2022	
Pneumovax 23	/ /			LT RT LD RD	10-30-2019	
Meningococcal (ACWY)	/ /			LT RT LD RD	8-6-2021	
Men B (Bexsero)	/ /			LD RD	8-6-2021	
Flu (6 mo.-18 yrs)	/ /			LT RT LD RD	8-6-2021	

NURSE COMMENTS:_____

NEXT RETURN DATE: _____

ALLEN COUNTY
PUBLIC HEALTH

CLIENT INSURANCE AUTHORIZATION

Consent for assignment of benefits: I authorize Allen County Public Health to bill my insurance and assign the payment of these benefits directly to Allen County Public Health. I assign Allen County Public Health all rights to benefits, insurance payments, insurance reimbursements, or other payments or judgements to which I may be entitled for services provided to me at Allen County Public Health. I understand that I am responsible for any amounts not paid by my health insurance or any other insurance plan or policy, including but not limited to, any deductibles, copays, and coinsurance amounts provided under any coverage source and charges for which there is no coverage source.

Choice #1 Please give your **private insurance** or **Medicaid** card to the clerk to copy if you are authorizing us to submit to your insurance.

Primary Cardholder's Name_____ Birth date____/____/_____

Signature _____ Date _____

Choice #2 ☐ I **do not** have private insurance or Medicaid coverage for myself or my child.
☐ I have insurance but the vaccine or service is not covered by the insurance.

Signature _____ Date _____

Choice #3 This choice means I will ***self-pay*** for all services & fees.
☐ Allen County Public Health is a non-participating provider with my health insurance.
☐ I ***do not*** give permission for my insurance agency to be billed for services.

Signature _____ Date _____

For office use only

Insurance coverage _____ Date verified _____

ACPH Rep_____