



2024 ADOLESCENT VACCINATION CONSENT FORM

(Tdap, HPV, Meningococcal ACWY)

Name: Last First Middle

Date of Birth: / / Age: Gender: M F

If minor - parent/guardian's name: Last First M.I.

Parent/Guardian's Date of Birth: / / Parent's SSN: Optional

Address: City: ZIP:

Grade: Home Room Teacher: School:

IMPORTANT Parent/Guardian Phone # Home: Cell: Work:

Emergency Contact: Emergency contact number: (If other than Head of Household)

My child will be 11 years of age or older on the day of the scheduled vaccination clinic: YES NO

Please check YES or NO to all the questions below to determine if your child can receive offered vaccines at school.

Table with 3 columns: Question, YES, NO. Contains 5 questions about allergic reactions, previous vaccine doses, seizures, Guillain-Barré Syndrome, and pregnancy.

If you answered YES to questions, this vaccine(s) may not be safe for your child and s/he WILL NOT receive these vaccines at school.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

- 1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids... 2. If your child should be directly exposed to blood or body fluids of a VDH health care professional...

\* Insurance\*: Please answer the following: This information is required for federal funding purposes for VFC vaccines.

\*Note: Vaccines will be provided to your child without cost to you if your child is eligible for the Vaccines for Children Program. If your child is covered by a private health insurance plan, the Department shall seek reimbursement for all allowable costs associated with the provision of the vaccine.

- My child: ( ) is not insured (not covered by private insurance, Medicaid, Medicaid MCO or FAMIS) ( ) is American Indian or is an Alaska Native ( ) has Medicaid MCO with: Sentara Community Care, Anthem Healthkeepers Plus, Molina Healthcare, United Healthcare Community Plan, or Aetna Better Health (circle your plan) Member ID # as shown on your card: is this a FAMIS plan? Y N ( ) has Medicaid or FAMIS (circle one) that is not a MCO plan: Medicaid # ( ) has other insurance not listed above (specify plan name) Policy ID # Policy holder's name

Attach a copy of the front & back of insurance card or provide the following information:

Insurance company address

Insurance company phone number

I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third-party payer to pay any authorized benefits to VDH on my behalf.

**Office of Privacy and Security**

Authorization for Disclosure of Protected Health Information

This consent gives the Virginia Department of Health (VDH) permission to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to my child cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that immunization records of my child will be retained for 21 years after birth.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

Please check box if you wish to receive a copy of the Virginia Department of Health Notice of Privacy Practices.

**CONSENT FOR CHILD'S HPV VACCINATION:**

- My child has NEVER been vaccinated for HPV. **Note: Your child will require two doses: the first dose now and the 2<sup>nd</sup> Dose 6 months after Dose 1. NOTE: children with certain medical conditions may require three doses. Please consult your provider to assess the need for a third dose.**
- My child has received the first dose of the HPV vaccine. **Note: the 2<sup>nd</sup> Dose should be received 6 months after Dose 1.**

I have read the 2021 Vaccination Information Statement (VIS) for the HPV Vaccine. I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the HPV vaccine (shot). **If needed, I give my consent for my child to receive the second dose approximately six months after the first dose.**

Signature of Parent or Legal Guardian:  \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**CONSENT FOR CHILD'S MenACWY VACCINATION:**

I have read the 2021 Vaccination Information Statement (VIS) for the MenACWY Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the Meningococcal ACWY vaccine (shot).

Signature of Parent or Legal Guardian:  \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**CONSENT FOR CHILD'S Tdap VACCINATION:**

I have read the 2021 Vaccination Information Statement (VIS) for the Tdap Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the Tdap vaccine (shot).

Signature of Parent or Legal Guardian:  \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Please send a copy of my child's immunization record to her/his doctor at the following address.

Doctor's Name \_\_\_\_\_ Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

HEALTH DEPARTMENT USE ONLY						
Date	Item code	Fund Source	Lot Number	Vaccine Administration Site		Provider #
	Tdap	VFC STF		RA	LA	
	MenACWY	VFC STF		RA	LA	
	<del>HPV #1</del>	<del>VFC STF</del>		<del>RA</del>	<del>LA</del>	
	<del>HPV #2</del>	<del>VFC STF</del>		<del>RA</del>	<del>LA</del>	
		VFC STF		RA	LA	
Comments						
Provider Name/Signature and Date						