2020 STUDENT Tdap VACCINATION CONSENT FORM

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)

Health Department Use Only
Cli ID#: _____
Encounter #: _____
Receipt #: _____

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 of the questions below to determine if your child can receive the Tdap vaccine. The nurse giving the vaccine will review this information on the vaccine clinic day.

		YES	NO
1.	Has your child ever had a life threatening allergic reaction after a dose of any tetanus, diphtheria, or pertussis containing vaccine?	❑	❑
2.	Does your child have a severe allergy to any component of the Tdap vaccine?	❑	❑
3.	Did your child experience a coma, or long or multiple seizures within seven days following a dose of DTP or DTaP?	❑	❑
4.	Does your child have epilepsy or another nervous system problem; ever had severe swelling or severe pain after a previous dose of DTP, DTaP, DT, or Td; or ever had Guillain-Barré Syndrome (GBS)? If so, consult your doctor about receiving Tdap vaccine.	❑	❑

If you answered YES to any of the questions above Tdap vaccine may not be safe for your child and s/he WILL NOT receive this vaccine 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 in a way that may transmit disease, I understand that the law requires my child to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. 2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

Turn to the back of the form

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 charge if the 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. **Your child will not be vaccinated if you do not provide all requested insurance information below.**

My child: ( ) is *not* insured (not covered by private insurance, Medicaid, or FAMIS)
( ) is American Indian or is an Alaska Native
( ) has Medicaid - Medicaid #: _____
( ) has FAMIS - FAMIS #: _____
( ) has other insurance not listed above (specify plan) _____
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 21years 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 VACCINATION:
I have read the 2020 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: X **_____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 #
		VFC STF		RA LA	
Comments					
Provider Name/Signature and Date					