Office Use Only
CA/CK

School Immunization & Flu Clinic Information
6th Grade only

Dear Parent or Guardian:

Your school and Weber Morgan Health Department (WMHD) are pleased to announce they are partnering to provide an Immunization Clinic at your child's school. It is recommended that everyone over 6 months of age receive an annual influenza vaccine to prevent illness and hospitalizations. Tdap, HPV, and Meningococcal vaccine are recommended for all students entering 7th grade. School nurses and WMHD nurses will be offering these vaccinations to all 6th grade students at your child's school. Parents and siblings are welcome to attend with their child and may receive vaccinations at the same time.

- **For Clinic dates and times,** see the attached calendar.
- **Please read the vaccine information statements at** www.webermorganhealth.org or call 801-399-7250 for a paper copy. They will answer questions you may have regarding these vaccines.
- **Please fill out both sides of this form.**
- **Please send the completed form back to the school on the day of the clinic**.
- You can also find copies of this form & the calendar at www.webermorganhealth.org or your school website.

Weber Morgan Health Department can bill the following insurance companies if your child is covered by them:

- Aetna/Altius
- Blue Cross Blue Shield* (*Except Focal Point)
- CHIP
- Deseret Mutual
- Educators Mutual
- GEHA
- Medicaid
- PEHP
- Samera Health* (*T&C Network Only)
- Select Health
- TRICARE* (*May need referral from PCP)
- UMR
- United Health Care* (*Except Railroad Employees)
- University of Utah

Please choose one of the following payment categories:
(*If you have more than one insurance, please check ALL that apply.)

☐ My child has Medicaid or CHIP. ***Please attach a copy of Medicaid/CHIP card.*
(All information must be completed in order for us to bill)
HMO/ACO Name: _____ Policy/Member ID #: _____

☐ My child has one or more of the insurances listed above. ***Please attach a copy of insurance card(s).*
(All information must be completed in order for us to bill your insurance)
#1 Insurance Name: _____ Policy #:_____ Group #:_____
Policy Holder Name: _____ Policy Holder Date of Birth: _____

#2 Insurance Name: _____ Policy #:_____ Group #:_____
Policy Holder Name: _____ Policy Holder Date of Birth: _____

☐ **My child has NO insurance**. Please attach the following: Flu $20, Tdap $20, HPV $20, Meningococcal $20.*

☐ **My child has insurance that pays for immunizations but it is NOT listed on this form**
–OR–

☐ **My child has insurance, but it does NOT cover vaccinations.**
Please attach the following: Flu $30, Tdap $56, HPV $260, Meningococcal $124.*

**If payment is indicated, it needs to be sent with the consent form on the day of the clinic*.

Cash or check is acceptable. Please make check payable to "WMHD".
If you would like us to send you an itemized receipt to submit to your insurance – please call (801)399-7250.

Payment information must be filled out on the front of this form.

WEBER MORGAN HEALTH DEPARTMENT
Encounter – Permission Form 6th grade

Please fill out the following information for the person receiving the vaccine.

Legal Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ ZIP Code: _____

Telephone #: _____ Cell Phone #: _____

Race: _____ Ethnicity: _____ Sex: _____ School Child is Enrolled in: _____

Mother's Maiden Name: _____

I have read, or had explained to me, the information contained in the Vaccine Information Statement for the person receiving the vaccine(s). I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) be given to me or the person for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, healthcare providers and others when medically necessary. I understand that it is my responsibility to know what my insurance plan covers and agree to pay the portion not covered by my insurance. I understand that if Weber Morgan Health Department does not have a contract with my insurance company, or my insurance company denies payment, I am responsible for all charges incurred. I am hereby notified that the Weber Morgan Health Department's Notice of Privacy Practices and Vaccine Information Statements are located on their web site at www.webermorganhealth.org and I have had a chance to ask questions about how my public health information will be used.

Has the person receiving the vaccine:

1.	been ill in the last week with anything more severe than a cold?	☐ No	☐ Yes
2.	had a serious reaction to a previous vaccination?	☐ No	☐ Yes
3.	been paralyzed by Guillain-Barre Syndrome?	☐ No	☐ Yes
4.	had a serious allergy to any foods or medications?	☐ No	☐ Yes
	If yes, please list: _____		
5.	had a seizure, brain, or nerve problem?	☐ No	☐ Yes
6.	I would like my child to have the Flu vaccine today:	☐ No	☐ Yes
7.	I would like my child to have the Tdap vaccine today:	☐ No	☐ Yes
8.	I would like my child to have the HPV vaccine today:	☐ No	☐ Yes
9.	I would like my child to have the Meningococcal (MCV4) vaccine today:	☐ No	☐ Yes

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____

*** Space below for Office Use Only***

The Stock Used is: VFC ☐ **Weber** ☐ **Date:** _____

Vaccine(s) Given: **Site:**

☐ Flu _____ 0.5cc	☐ L ☐ R Del
☐ Tdap _____ 0.5cc	☐ L ☐ R Del
☐ Meningococcal _____ 0.5cc	☐ L ☐ R Del
☐ HPV _____ 0.5cc	☐ L ☐ R Del

Nurse's Initials: _____

Notes: _____