

Please choose one of the following payment categories:

- My child has no insurance. Please attach a \$6 payment.
- My child has insurance, but it does not cover vaccinations. Please attach a \$6 payment.
- My child has Medicaid/CHIP HMO Name: _____ Policy # _____.
- My child has one of the insurances listed on the front of this form.
Insurance Name _____ Policy # _____.
Policy Holder Name: _____ Policy Holder Date of Birth _____.
- My child has insurance that pays for immunizations but it is not listed on this form. Please attach a \$45 payment. Please check if you would like a detailed receipt mailed to your home. Yes, please mail.

Cash or check is acceptable. Please make check payable to "WMHD"

**WEBER MORGAN HEALTH DEPARTMENT- MIDTOWN COMMUNITY HEALTH CENTER
Encounter – Permission Form**

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 Name: _____ Father's Name: _____.

I have been given a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement about the Tdap disease(s) and vaccine. I understand the benefits and risks of the vaccine and request that the vaccine 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 is 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 DTaP vaccination?
See #4 in the Vaccine Information Statement (attached) No Yes
- 3. ever had a serious allergy to any foods or medications? No Yes

Parent/Guardian Signature: _____.

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

Preferred language _____ ; Homeless Yes No; Migrant or Seasonal Farm Worker Yes No

VFC SP C3921AA 0.5 cc **Weber** SP C4009BA 0.5 cc

Site _____ Date _____ Nurse's Signature _____.