Bartholomew County Health Department

Public Health Nursing

2675 Foxpointe Drive, Suite B • Columbus, IN 47203

Phone: (812) 379-1555 • Fax (812) 379-1559

2019 School based Vaccination Clinics
Sponsored by Bartholomew County Health Department

September 23, 2019

Dear Parents,
The Center for Disease Control (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommend that all students should be immunized against vaccine preventable diseases.

To assist you in complying with this recommendation, the Bartholomew County Health Department, with great cooperation with Bartholomew County School Corporation as a Senior Project, will be offering a Meningococcal vaccine clinic on December 3, 2019.

To receive a vaccine(s) at no charge from the Health Department you must meet **one** of the following categories:

1. Be uninsured
2. Be underinsured- meaning your insurance will not cover the cost of immunizations.
3. Medicaid recipient
4. Be American Indian/Alaskan Native

You may contact the school nurse or Bartholomew County Health Department to verify immunization status prior to this clinic.

Please fill out the attached 2 sided consent form for your child to participate in the immunization clinic and return to the school nurse by November 5th.

Immunizations are offered at the Bartholomew County Health Department on Mondays and Tuesdays 8am-10:45am and 1pm-3:45pm by appointment only.
Please do not hesitate to contact the Bartholomew County Health Department at 812-379-1555 opt 1 if you have any questions.

Sincerely,

Amanda Organist, RN, BSN
Director of Nursing
Bartholomew County Health Department

School Immunization Clinic Parental Consent Form

In order for your child to obtain a vaccine in the arm during this school based clinic, you must complete this form entirely. Please print.

A. School Name_____ Grade_____ Teacher_____

Student Information:

Last name_____ First name_____ Full middle name_____

Student's birth date _____ Age_____ Male Female

Address_____ City_____ Zip code_____

Parent/Guardian Information:

Last name_____ First name_____ MI_____

Phone number_____ Relationship to student_____

B. Vaccine Eligibility Screening (please check appropriate box)

☐ Medicaid medicaid #_____ ☐ American Indian/Alaskan Native

☐ No health insurance ☐ Limited insurance- insurance does not cover Vaccines

☐ Insurance

C. Health Screening

Please answer all questions about the student who will be receiving the vaccine. Answers will determine whether the student can be vaccinated at this time. If you respond 'YES' to any of the questions, please explain in the space provided.

YES NO 1. Does the student have any allergies to medication, food (eggs), or any vaccines?

YES NO 2. Has the student had a serious reaction to a vaccine in the past?

YES NO 3. Has the student had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?

YES NO 4. Has the student had a seizure, brain or other nervous system problem, including Guillain-Barré Syndrome?

YES NO 5. Does the student have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?

YES NO 6. Has the student taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?

YES NO 7. Has the student received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?

YES NO 8. Is the student pregnant or is there a chance she could become pregnant during the next month?

YES NO 9. Has the student received vaccinations in the past four (4) weeks?

YES NO 10. Is the student receiving aspirin therapy or aspirin-containing therapy?

YES NO 11. Is the student that is being vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g. an isolation room of a bone marrow transplant unit)?

Please explain any YES responses

_____

_____

D. Consent to Vaccinate

I have been given a copy and I have read or had explained to me, the information in the Vaccine Information Statement(s) for the vaccines. I have had a chance to ask questions and fully understand the benefits and risks of the indicated vaccine and ask that the following vaccine be given to my child on the scheduled school clinic date. Vaccine date will be entered in CHIRP. I request that the vaccine(s) checked be given to the student named above.

☐ Meningococcal (MCV4) ☐ Meningococcal B

I give permission to the Bartholomew County Health Department to vaccinate the student named on this form.

Signature of Parent/Guardian_____ Date_____

E. To Be Completed By Person Administering Vaccine

Vaccine	Lot Number & Expiration Date	Route	VIS Date	Nurse Signature
MCV4- VFC		IM	8/15/19	
MCV4- PVT		IM	8/15/19	
Men B- VFC Bexsero		IM	8/9/16	
Men B- PVT Bexsero		IM	8/9/16	
Men B- VFC Trumenba		IM	8/9/16	
Men B- PVT Trumenba		IM	8/9/16	

Entered into CHIRP by _____ Date _____