2018/19 MENINGOCOCCAL VACCINE CONSENT FORM

Information about person to be vaccinated ***(Please print)***

Last Name:_____

First Name: _____ Age: _____

Date of Birth: _____ Sex: _____ M _____ F

Address: _____

City: _____ Zip: _____

Parent/Guardian: _____

Phone number: _____

(For office use only): Hamlin County OCFS #128

300 4th Street

phone:(605)783-3681 Hayti SD 57241

If history of previous dose, check SDIIS

Two doses are recommended for adolescents 11-18 yrs.
1st dose at age 11-12, with a booster dose at age 16

★ State Law requires I dose for Middle School entry

★ If the 1st dose is given between age 13-15, a booster dose should be given between 16-18

★ If 1st dose is given after 16th birthday, booster not needed

★ A dose on or after age 10 is considered a valid dose

The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota. SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information. Immunization records remain confidential, and any person who fails to protect the confidentiality of this information is guilty of a Class 1 misdemeanor. If you choose **NOT** to have your/your child's immunization record shared with other providers you may request a refusal form.

INSURANCE COVERAGE

_____ Enrolled in Medicaid **MUST ATTACH COPY OF CARD**

_____ No health insurance

_____ Insurance **MUST ATTACH COPY OF CARD**

_____ American Indian or Alaskan Native

_____ Health insurance DOES NOT pay for vaccines **MUST ATTACH COPY OF CARD**

For Dependent: Name of policy holder _____ **Date of Birth** _____ **Relationship** _____

Please answer the following questions for the person to be vaccinated:

	Yes	No	Don't Know
1) Is the child sick today?			
2) Does the child have allergies to medication, food, a vaccine component, or latex?			
3) Has the child ever had a serious reaction to a vaccine in the past?			
4) Has the child received a previous dose of meningococcal vaccine?	*		

* If previous dose given, please enter date if known: _____

I have been provided a copy of and have read or have had explained to me the information about meningitis and the vaccine listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.
If covered by private insurance, I authorize SDDOH to release medical information necessary to determine benefits payable for this service. I understand I am financially responsible regardless of insurance coverage.

Signature _____ **Date** _____

(Parent or guardian if minor)

For child being vaccinated at a school based clinic

If you are completing this form for a child to be vaccinated at school and you will not be accompanying him/her, please provide a phone number where you can be reached on the day of the clinic **PHONE:** _____

for office use only

** IM - Intramuscularly

	Type	Date/Time	Vaccine Manufacturer Circle One	Vaccine Lot number	Route	Site **(Circle)**	Date of VIS Publication	Full signature of person administering vaccine
Meningococcal	MenACWY		Menactra----- Sanofi Pasteur Menveo----- GlaxoSmithKline		IM**	L R Deltoid	08/24/18	

The Department of Health Notice of Privacy Practices can be found on the following website: http://doh.sd.gov/documents/HIPAANotice.pdf **3-25-18**