EXAMPLE COUNTY
PUBLIC HEALTH CENTER

Registration Form

Please complete the form below for your school or community-based clinic.

Student Information

Select the School your child currently attends

- ❑ Antioch Middle School
- ❑ Discovery Middle School
- ❑ Excelsior Springs High School
- ❑ Excelsior Springs Middle School
- ❑ Heritage Middle School
- ❑ Kearney High School
- ❑ Kearney Middle School
- ❑ Liberty Academy
- ❑ Liberty High School
- ❑ Liberty Middle School
- ❑ Liberty North High School
- ❑ Maple Park Middle School
- ❑ New Mark Middle School
- ❑ North City High School
- ❑ Northgate Middle School
- ❑ Oak Park High School
- ❑ Smithville High School
- ❑ Smithville Middle School
- ❑ South Valley Middle School
- ❑ Staley High School
- ❑ Winnetonka High School

Student Legal Name - First _____ Last _____ MI ____

Student Preferred Name - First _____ Last _____ MI ____

Date of Birth _____ Current Age _____ Middle School clinics are for ages 11-14 • High School clinics are for ages 16-18

Race

- ❑ Declined
- ❑ Alaska Native
- ❑ American Indian
- ❑ Asian
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Caucasian
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Pacific Islander
- ❑ Other Race
- ❑ Vietnamese
- ❑ White

Ethnicity

- ❑ Declined
- ❑ Hispanic/Latino
- ❑ Not Hispanic/Latino

Gender

- ❑ Male
- ❑ Female
- ❑ Declined

Preferred Language _____

Parent / Guardian Information

Name - First _____ Last _____ MI ____

Relationship to Student * (only the custodial parent may provide consent. If another guardian is providing consent, guardian paperwork is required. Guardianship paperwork may be emailed to imms@examplecounty.com or faxed to 816-555-1212.

- ❑ Custodial/Biological Parent
- ❑ Step-Parent
- ❑ Guardian
- ❑ Self/Student if age 18 and older
- ❑ Other

Phone _____ ❑ Cell ❑ Home ❑ Work ❑ Other

Alternate Phone _____ ❑ Cell ❑ Home ❑ Work ❑ Other

Email Address _____

Address _____ City _____ State ___ Zip _____

Please go to next page

Vaccines

Which vaccines will your student be receiving at the School Clinic? Check all applicable.

❑ Tdap (Adacel®) - Required for Middle School ONLY

Tdap vaccine protects against tetanus, diphtheria, and pertussis (whooping cough). Tetanus infection causes painful stiffening of the muscles and can lead to serious health problems including being unable to open the mouth, having trouble swallowing and breathing, or death. Diphtheria infection can lead to difficulty breathing, heart failure, paralysis, or death. Pertussis can cause uncontrollable, violent coughing that makes it hard to breathe, eat, or drink. In teens and adults, pertussis can cause weight loss, loss of bladder control, passing out, and rib fractures from severe coughing.

❑ Meningococcal/ACWY (Menactra® or MenQuadfi®) - Required for Middle and High School

Meningococcal/ACWY vaccine can help protect against meningococcal disease caused by serogroups A, C, W, and Y. Meningococcal disease can cause meningitis or infections of the blood. Even when treated, meningococcal disease kills 10% to 15% of the people infected. Of those that survive, 10% to 20% suffer disabilities including hearing loss, brain damage, kidney damage, loss of limbs, nervous system problems, or severe scars from skin grafts. A different meningococcal vaccine (offered below) can help protect against serogroup B.

❑ HPV (Gardisil® 9) - Middle and High School – Recommended

HPV vaccine can prevent over 90% of the cancers caused by human papillomavirus. These cancers include cervical and vaginal cancers in people born female, penile cancers in people born male, anal and throat cancers. There are approximately 79 million Americans currently infected with HPV. (for ages 9 and older)

❑ Men B (Bexsero® or Trumenba®) - High School ONLY – Recommended

Meningococcal B vaccine protects against meningitis, an infection of the lining of the brain and spinal cord. It is a different strain of meningococcal vaccine than that required for 8th & 12th grades. It is recommended for students ages 16 to 23 years as they are at increased risk of infection. It is required by some colleges. (for ages 16 and older)

❑ Influenza – Recommended

Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year. It also reduces the chance that your child will need to miss school. (for ages 6 months to adult).

Insurance Information

If the child has private insurance or insurance that does not cover vaccines providing this information regardless of coverage is required. Failure to do so may result in delaying the registration process and/or your child not being able to be seen at this clinic. *

❑ Uninsured

❑ Insurance does not cover vaccines

❑ Medicaid

DCN Number _____

❑ Tricare

Policyholder Name - First _____ Last _____ MI ____

Relationship of Policyholder to Student _____ Policyholder Date of Birth _____

Policyholder Address _____ City _____ State ___ Zip _____

Policyholder Gender ❑ Declined ❑ Female ❑ Male ❑ Unknown ❑ Other _____

DOD No. _____ Social Security No. _____

❑ Private Insurance

Insurance Company Name _____ Policy No. _____ Group No. _____

Policyholder Name - First _____ Last _____ MI ____

Relationship of Policyholder to Student _____ Policyholder Date of Birth _____

Policyholder Address _____ City _____ State ___ Zip _____

Policyholder Gender ❑ Declined ❑ Female ❑ Male ❑ Unknown ❑ Other _____

Please go to next page

Authorization and Consent

Select "I agree" to give permission for the Example County Public Health Center to vaccinate the student named on this form. I attest that If I had questions, I contacted the Example County Public Health Center at 816-555-1212 and my questions were answered. I fully understand the benefits and risks of each of the indicated and ask that the vaccines selected above be given to my child on the scheduled school clinic date.

❑ I Agree

Vaccine Information Statements

Select "I agree" to acknowledge that you were provided vaccine information statements.

❑ I Agree

Privacy Policy

Select "I agree" to acknowledge that you were provided with Example County Public Health Center's privacy notice.

❑ I Agree

Personal Financial Responsibility

By signing this form, and in return for the services rendered by Example County Public Health Center (ECPHC), I am personally responsible for all fees not paid by any third party on my behalf.

❑ I Agree

Select "I agree" to give permission to Example County Public Health Center to vaccinate the student named on this form.

❑ I Agree

Electronic Signature Agreement

Patient Signature – Draw your signature below using a tablet, mouse or smartphone. By clicking the Submit button at the end of this form you understand and agree that 1) your application will not be signed in the sense of a traditional paper document, 2) by signing in this alternate manner, you authorize your electronic signature to be valid and binding upon you to the same force and effect as a handwritten signature, 3) you may still be required to provide a traditional signature at a later date, and 4) by submitting this form you are approving ECPHC to send an automatic reply to the email address provided verifying the student's participation in this clinic.

If under the age of 18 please have parent or guardian sign

_____

By submitting this form you are approving ECPHC to send an automatic reply to the email address provided verifying the student's participation in this clinic and/or you are approving ECPHC to contact you via phone call or text if additional information is needed.

Please go to next page

EXAMPLE COUNTY
PUBLIC HEALTH CENTER

Student Screening Form

Please answer questions about the person receiving the vaccine(s)

The following questions will help us determine which vaccines your student may be given. If you answer yes to any question, it does not necessarily mean they should not be vaccinated. It means additional questions must be asked. If a question is not clear, please call 816-555-1212.

School _____ Student Name _____ DOB _____ Age _____

1. Do you have allergies to medications, food, a vaccine component, or latex?
   ❑ Yes ❑ No

2. Have you had a serious reaction to a vaccine in the past?
   ❑ Yes ❑ No

3. Do you have a health problem with lung, heart, kidney, or metabolic disease, i.e., diabetes, asthma, or a blood disorder? Are you on long term aspirin therapy?
   ❑ Yes ❑ No

4. Have you ever had a seizure, or had a brain or other nervous system problem?
   ❑ Yes ❑ No

5. Does the student have or live with someone who has cancer, leukemia, HIV/AIDS, or immune system problems?
   ❑ Yes ❑ No

6. In the past 3 months, have you taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?
   ❑ Yes ❑ No

7. In the past year, have you received a blood transfusion or blood products, or have been given a medicine called immune (gamma) globulin or an antiviral drug?
   ❑ Yes ❑ No

8. Have you received any vaccinations in the past 4 weeks?
   ❑ Yes ❑ No

9. Are you nursing, pregnant, or is there a chance you could become pregnant during the next month?
   ❑ Yes ❑ No

10. To be answered the day of clinic – Are you sick today?
    ❑ Yes ❑ No

Form completed by _____ Phone _____ Date _____