CureMD____ NICR____

e-Bill_____ Scanned___

School: _____

Date Form Received by School: _____

Guilford County Department of Health and Human Services
Public Health Division
Immunization Permission Form

Child's Information (please print):

Last name _____First name _____ Middle Initial _____

Date of Birth _____ Age _____ Sex _____ Race _____

Ethnicity: Hispanic / Non-Hispanic Social Security Number: _____- _____ -_____

Address _____

City _____ Zip Code _____

Parent's Daytime phone number (____) _____Evening phone number (___) _____

Emergency Contact Information (please print):

Contact Name _____ Daytime phone number (___) _____

Contact's relationship to child _____

Permission for Immunizations:

☐ **Yes**, as the parent/guardian, I give my permission for my child _____

- To receive Tdap and/or Meningococcal vaccine(s) at his/her school. I have received, read, and understood the Vaccine Information Sheet(s) about the disease(s) and for the vaccine(s) listed.
- I have had an opportunity to have my questions answered by my child's medical provider or by the Guilford County DHHS – Public Health Division to my satisfaction.
- I have received, read, and understood the information in the attached Health Insurance Portability and Accountability Act (HIPAA) consent.
- I give authorization to Guilford County DHHS – Public Health Division to disclose specific health information for my child for the purpose of treatment, payment, and/or operations as stated in the HIPAA consent

☐ **No**, as the parent/guardian, I do **NOT** want my child _____ to receive Tdap and/or Meningococcal vaccine(s) at his/her school.

Parent/Guardian signature _____ **Date** _____

Child's Insurance Information. This information is required. **Please check the appropriate line:**

☐ My child has Medicaid. The Medicaid number is _____

☐ My child has no insurance coverage

☐ My child has other insurance coverage:

☐ United Health Care policy **AND** group number _____
Name of PCP listed on card _____

☐ Blue Cross Blue Shield policy **AND** group number _____
Name of PCP listed on card _____

☐ Name of other insurance _____
Policy **AND** Group number _____
Name of PCP listed on card _____

Immunization Questions:

Please circle "Yes" or "No" for each of the following questions. All questions **MUST** be answered for your child to receive Tdap and/or Meningococcal vaccine(s) at his/her school.

Does your child have any allergies, including to either vaccine or any agents used to make the vaccine(s)?	Yes	No
Does your child have a history of Guillain-Barré Syndrome?	Yes	No
Has your child had a seizure after receiving DTP/DTaP?	Yes	No
Does your child have a seizure or nervous system disorder?	Yes	No
Date of last menstrual period / / Is your child pregnant?	Yes	No
Who is your child's medical doctor (or practice name)?		

For Local Health Department Use Only for Tdap
Vaccine: ICD-10 Z23
CPT: 90715 90715SL
Admin Code: 90471 Modifiers: EP TJ NC

Date	Vaccine	Eligibility	Route	Lot #	Expire Date	Nurse Signature
	TDAP	STATE or FEE	IM			

For Local Health Department Use Only:
Menquadfi Vaccine: ICD-10 Z23
CPT: 90619 90619SL
Admin Code: 90471 90472 Modifiers: EP TJ NC

Date	Vaccine	Eligibility	Route	Lot #	Expire Date	Nurse Signature
	MENQUADFI	STATE or FEE	IM			

Comments/Notes: _____

_____

_____