



MARGARET MARY HEALTH

Occupational Health & Wellness Center
1051 State Road 229 N • Batesville, IN 47006
Phone: 812.932.5105

ONSITE HEALTH SCREENING FOR VACCINES

Child's First Name: _____ Child's Last Name: _____ Age: _____ Date of Birth: _____

- 1. Does your child have any allergies to medications, foods or vaccines? Mark any allergies:** Yes No
- Eggs Yeast Sulfa Penicillin
 Streptomycin Gelatin Latex Neomycin
 Other: _____

- 2. Has your child ever had a severe reaction to a vaccine in the past? (i.e. temperature > 105°, crying more than three hours) If yes, which vaccine and what was the reaction?** _____ Yes No
- _____

- 3. In the past two weeks, has your child received any vaccinations or a tuberculin skin test?** Yes No

- 4. Has your child ever had an unexplained seizure, brain or other nervous system problem, encephalopathy or Guillan-Barre syndrome. If yes, please explain:** _____ Yes No
- _____

- 5. For females - Is your daughter pregnant? (Many vaccines should not be given to women known to be pregnant. Pregnancy should be avoided for four weeks following receipt of a live virus vaccine.)** N/A Yes No

- 6. Does your child have a weakened immunity due to a medical condition, medication or treatment? Mark which apply:** Yes No

- Cancer Stem cell transplant Radiation treatments
 Lymphoma Anti-tumor agents Anti-cancer medications
 Leukemia Low T-Lymphocyte count
 AIDS/HIV Crohn's/Psoriasis
 Large doses of cortisone, prednisone, other steroids (>20 mg/day for 2+ weeks)
 Taking medication for rheumatoid arthritis
 Malignant conditions affecting the bone marrow or lymphatic system
 Other: _____

- 7. In the past year, has your child received a transfusion of blood or blood products, been given immune gamma globulin or an antiviral drug. If yes, when:** _____ Yes No

- 8. HPV (Gardasil) vaccine is highly recommended for males and females ages 9 through 45.** This vaccine protects against genital warts and cervical cancer. For children ages 9 to 14, two doses are recommended separated by six months. For those 15 years old and older, three doses of the HPV vaccine are recommended at 0, 2 and 6 months. Would you like your child to receive this vaccine? N/A Yes No

- 9. Meningitis B - For 16 to 23 year olds.** In June 2015, a new and additional meningitis vaccine containing serogroup B became available. This is an optional vaccine for high school students but required by many Indiana colleges/universities. The new meningitis vaccine is a series of two doses separated by approximately six months. Would you like your child to receive the Meningitis B vaccine? N/A Yes No

- 10. After reviewing your child's immunization record, all routine immunizations will be given to your child to meet state requirements. List any vaccine(s) you do NOT want your child to receive here:** _____

Parent/Legal Representative Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____



Occupational Health & Wellness Center
 256 State Road 129 N.
 Batesville, IN 47006
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ONSITE VACCINE CONSENT

Patient First Name: _____ Patient Last Name: _____ Date of Birth: _____
 Gender: Male Female Home/Cell Phone Number: _____ E-mail: _____
 Home Address: _____ City: _____ State: _____ Zip Code: _____
 Please select one: Employee Place of Employment: _____
 Student School: _____ Grade: _____

Emergency Contact Information:

First Name: _____ Last Name: _____ Date of Birth: _____
 Relationship: _____ Home/Cell Phone Number: _____

Insurance: Please contact your insurance company to verify eligibility, coverage and location limitations. Some insurance companies will not cover vaccines administered in the school setting. Immunizations are billed as 'preventative' and may be covered under the wellness category of your insurance plan. Our provider is Michael Parker, DO. The insurance company makes the final determination of your eligibility and coverage.

Select One:

- No Health Insurance.**
- Insurance Does Not Cover Vaccines.**
- Medicaid.** Charges will be submitted to Medicaid. A copy of both sides of the insurance card is required to be sent with this form.
- Insurance Covers Vaccines.** Charges submitted to insurance. A copy of both sides of the insurance card is required to be sent with this form. **Complete Insurance and Guarantor's sections below.**

Name of Insurance Company: _____
 Member ID Number: _____ Group Policy Number: _____
 Address to Send Claims: _____

Guarantor's Information (Person carrying insurance):

Legal First Name: _____ Legal Last Name: _____ Social Security Number: _____
 Date of Birth: _____ Relationship to Patient: _____ Home/Cell Phone Number: _____
 E-mail: _____
 Home Address: _____ City: _____ State: _____ Zip Code: _____
 Employer: _____ Full Time Part Time
 If Guarantor works for school system (SISIT), which school? _____

Acknowledgment and Signature: By my signature below, I represent I am the patient or I am the patient's legal representative and the guarantor of the patient's account pursuant to the financial acknowledgment described above. I represent I have fully read and understand each page of this five (5) page Patient Consent and Conditions of Treatment document, and I agree to be bound by its terms. I acknowledge all of my questions regarding this consent document have been answered to my full and complete satisfaction. I understand I have the right to revoke this consent at any time, except to the extent MMH or practitioners have acted in reliance on it.

The Patient Consent and Conditions of Treatment can be found at mmhealth.org/privacy-policy/
 Vaccine Information Sheets can be found at cdc.gov/vaccines/hcp/vis and have been reviewed.

Patient/Legal Representative Signature: _____ Today's Date: _____
 Printed Name: _____ Relationship to Patient: _____

