IMMUNIZATION PERMISSION FORM
Eleventh Grade School Site MCV Immunization Initiative

Please complete both sides of this form and return to your child's school no later than March 29, 2021.

VACCINATION AUTHORIZATION

☐ Yes, I give permission for my child to receive the **meningococcal conjugate vaccine (MCV)** as indicated at school. I have read the *Vaccine Information Sheet* for MCV and have had my questions answered.

_____ _____

Parent/Guardian Signature Date

INFORMATION ABOUT YOUR CHILD

Child's Name:		Date of Birth:	
Race:	Sex: Male or Female	Teacher:	
Parent/Guardian's Name:		Phone Number:	
Address:			
City:		State:	ZIP:

☐ This child has allergies to: _____

PREVIOUS MCV/TDAP VACCINATION STATUS

☐ This child has ALREADY received a **meningococcal conjugate vaccine (MCV)**.

If box is checked, please provide a record of the vaccination with this form.

VACCINE COST AND BILLING INFORMATION

The MCV vaccine alone costs $135.

Children who have no insurance, Medicaid, or Health Choice receive these vaccines at no cost. Many private insurance carriers cover vaccines at 100%.

If your child has insurance coverage through Blue Cross Blue Shield or Cigna we can file a claim on your behalf for your child's vaccinations. **Your signature above authorizes Transylvania Public Health to release information necessary for the processing of any claim for payment. You will receive an invoice for the amount not covered by insurance.**

If you have a different private insurance carrier, we will accept payment via check made payable to Transylvania Public Health or by contacting us at 828-884-3135 and asking to arrange for pre-payment of the school MCV vaccine. We will provide a receipt for you to claim reimbursement from your insurance carrier.

(over)

FEDERAL FUNDING/INSURANCE INFORMATION

Note: This information is required for insurance billing and federal funding purposes. It will not prevent your child from receiving vaccines through this program and will not be shared with anyone.

☐ This child is American Indian or Alaskan Native

This child has the following insurance coverage: **(*this information is very important for billing purposes)***

☐ Not insured / no medical coverage
☐ Has Medicaid Coverage: Recipient I.D. _____ - _____- _____
☐ Has North Carolina Health Choice for Children Insurance: Policy # _____
☐ Private Insurance: Company Name _____
Subscriber Name _____ Member (child) # ____ (01, etc.)
Subscriber ID _____ Subscriber DOB _____

ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that Transylvania County has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true and sign below:

☐ I have received the Transylvania County's Privacy Notice.
☐ I have been given a chance to discuss my concerns and questions about the privacy of my health information.

_____ _____
Patient Signature (Parent/Guardian Signature if patient under 18) Date

For office use only:

Transylvania County staff should complete if Acknowledgment Form is not signed:

1. Does patient have a copy of the Privacy Notice?
   ☐ Yes ☐ No
2. Please explain why the patient was unable to sign an acknowledgement form and Transylvania County's efforts in trying to obtain the patient's signature:

For local health department only: Consent form should be present with the child at the time of vaccination for verification of parental consent and accurate documentation.

Date Vaccine Given	Type of Vaccine	Site/ Route	Mfr./ Lot #	Date VIS Printed	Date VIS Given	Nurse Signature
	MCV	L R Deltoid/ IM		8/15/19	03/17/21	

Checked NCIR: ☐ YES ☐ NO