Spencer Hospital
Clay County Public Health
Healthier Together.

Adolescent Immunization Screening and Consent Form

CHILD'S PERSONAL INFORMATION: (PLEASE PRINT)

Last _____ First ___ _____ M.I. ____ Gender _____

Birthday _____ Age _____

Address _____ City _____ Zip Code _____

Phone # _____ Email Address: _____

Parent / Guardian_____ Physician _____

PARENTS/GUARDIANS: Please complete questionnaire for each (pre) teen receiving immunizations.			
	Yes	No	Unsure
1. Is your (pre) teen sick today?	☐	☐	☐
2. Does your (pre) teen have allergies to a vaccine component or to latex?	☐	☐	☐
3. Has your (pre) teen had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has your (pre) teen had brain or other nervous system problems?	☐	☐	☐
5. Is your teen pregnant?	☐	☐	☐
6. I consent for my (pre) teen to receive the **HPV-9 vaccine**.	☐	☐	
7. I consent for my (pre) teen to receive the **Tdap vaccine**.	☐	☐	
8. I consent for my (pre) teen to receive the **Meningococcal ACWY vaccine**.	☐	☐	
9. I consent for my teen to receive the **Men B vaccine**. (16 and older 2 dose series)	☐	☐	
HEALTH CARE COVERAGE			
10. Is the (pre) teen covered by Medicaid/Title 19?	☐	☐	☐
11. Is the (pre) teen covered by HAWK-I health insurance?	☐	☐	☐
12. Is the (pre) teen coved by health insurance (not Medicaid)? If yes, does your insurance include immunizations as a benefit?	☐ ☐	☐ ☐	☐ ☐
13. Is the (pre) teen American Indian or Alaskan Native (AI/AN)?	☐	☐	☐

CONSENT and RELEASE

I have been given an opportunity to review the Vaccine Information Statements for the vaccines recommended for my (pre)teen today. I give consent for my (pre)teen to receive these vaccines and I understand their benefits and risks. I am the parent or legal guardian of this child and have legal authority to consent to the administration of this vaccine to the person named on this form.

Parent/Guardian's Signature: _____

Relationship to (pre) teen: _____