Office Use Only
CA/CK

School Immunization Clinic Information
Adult Form

Your school and Weber Morgan Health Department (WMHD) are pleased to announce they are partnering to provide an Immunization Clinic at your school. It is recommended that everyone over 6 months of age receive an annual influenza vaccine to prevent illness and hospitalizations. Tdap, MMR, and Varicella vaccines are required for all school staff. School nurses and WMHD nurses will be offering these vaccinations to all staff at your school. Hepatitis B vaccine is also recommended and will be offered as well.

- **For Clinic dates and times,** see the attached calendar.
- **Please read the vaccine information statements at** www.webermorganhealth.org or call 801-399-7250 for a paper copy. They will answer questions you may have regarding these vaccines.
- **Please fill out both sides of this form.**
- **Please send the completed form back to the school on the day of the clinic**.
- You can also find copies of this form & the calendar at www.webermorganhealth.org or your school website.

Weber Morgan Health Department can bill the following insurance companies if your child is covered by them:

- Aetna/Altius
- Blue Cross Blue Shield* (*Except Focal Point)
- CHIP
- Deseret Mutual
- Educators Mutual
- GEHA
- Medicaid
- PEHP
- Samera Health* (*T&C Network Only)
- Select Health
- TRICARE* (*May need referral from PCP)
- UMR
- United Health Care* (*Except Railroad Employees)
- University of Utah

Please choose one of the following payment categories:
(*If you have more than one insurance, please check ALL that apply.)

☐ **I have Medicaid/Medicare**. *****Please attach a copy of Medicaid/Medicare card.***
(ALL information must be completed in order for us to bill)
HMO/ACO Name: _____ **Policy/Member ID #:** _____

☐ **I have one or more of the insurances listed above**. *****Please attach a copy of insurance card(s).***
(ALL information must be completed in order for us to bill your insurance)
#1 Insurance Name: _____ Policy #:_____ Group #:_____
Policy Holder Name: _____ Policy Holder Date of Birth: _____

#2 Insurance Name: _____ Policy #:_____ Group #:_____
Policy Holder Name: _____ Policy Holder Date of Birth: _____

☐ **My insurance company is not listed above:**

Please attach the following: Flu $30, High Dose Flu $70, Tdap $56, MMR $103, Hepatitis B $116*

☐ **I do not have insurance**. Please attach the following: Flu $30, High Dose Flu $70, Tdap $20, MMR $103, Hepatitis B $20*

**If payment is indicated, it needs to be sent with the consent form on the day of the clinic*.

Cash or check is acceptable. Please make check payable to "WMHD".

If you would like us to send you an itemized receipt to submit to your insurance – please call (801)399-7250.

(If you need the varicella vaccine, please call Lyndsey (801)399-7239 to request the form and for us to bring it to the clinic)

WEBER-MORGAN HEALTH DEPARTMENT
Encounter – Adult Permission Form

Please fill out the following information for the person receiving the vaccine.

Legal Name: _____ Date of Birth: _____ Age: _____
(Please Print)
Address: _____ City: _____ ZIP Code: _____

Telephone #: _____ Cell Phone #: _____

Race: _____ Ethnicity: _____ Sex: _____ School Site: _____

I have been given a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement for the person receiving the vaccine(s). I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) be given to me or the person for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, healthcare providers and others when medically necessary. I understand that it is my responsibility to know what my insurance plan covers and agree to pay the portion not covered by my insurance. I understand that if Weber-Morgan Health Department does not have a contract with my insurance company, or my insurance company denies payment, I am responsible for all charges incurred. I am hereby notified that the Weber-Morgan Health Department's Notice of Privacy Practices is located on their web site at www.webermorganhealth.org and I have had a chance to ask questions about how my public health information will be used.

Has the person receiving the vaccine:

☐Yes ☐No 1. been ill in the last week with anything more severe than a cold?

☐Yes ☐No 2. been on antiviral medication in the last 48 hours?

☐Yes ☐No 3. had any vaccines in the last month?

☐Yes ☐No 4. had a serious reaction to a previous vaccination?

☐Yes ☐No 5. been paralyzed by Guillain-Barre Syndrome?

☐Yes ☐No 6. had a serious allergy to any foods or medications? If yes, please list: _____

☐Yes ☐No 7. had a seizure, brain, or nerve problem?

☐Yes ☐No 8. had thrombocytopenia (low platelet count)?

☐Yes ☐No 9. been on chemo/radiation therapy, anticancer drugs or steroid medications in the last 3 months?

☐Yes ☐No 10. had immune (gamma) globulin or blood transfusions in the last year?

☐Yes ☐No 11. have cancer, leukemia, AIDS, or any other immune system problem? If yes, please list: _____

☐Yes ☐No 12. (Females Only) Are you pregnant or planning to be pregnant in the next 4 weeks?

Requested Vaccine (s):

Influenza Injectable	☐
High Dose Flu Injectable (65+ Only)	☐
Tdap (Tetanus, Diphtheria and Pertussis)	☐
MMR (Measles, Mumps, and Rubella)	☐
Heplisav B (Hepatitis B)	☐

Signature: _____

*** Space below for Office Use Only***

Vaccine(s) Given: **Site:**

☐ **Weber** Flu _____ 0.5 cc ☐L ☐R Del **Date:** _____
☐ **Weber** High Dose Flu _____ 0.5 cc ☐L ☐R Del
☐ **Weber** MMR _____ 0.5 cc ☐L ☐R Del **Nurse's Initials:** _____
☐ **Weber** Tdap _____ 0.5 cc ☐L ☐R Del
☐ **Special Project** Tdap _____ 0.5 cc ☐L ☐R Del
☐ **Weber** Heplisav B _____ 0.5 cc ☐L ☐R Del
☐ **Special Project** Heplisav B _____ 0.5 cc ☐L ☐R Del

Notes:

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