March 15, 2016

Dear Parents:

**Tdap** (tetanus, diphtheria, and pertussis) vaccine and **MCV4** (meningococcal) vaccine is required for all incoming eighth (8th) grade students.

Your child’s school immunization record indicates he/she needs Tdap and/or Meningococcal vaccine. Nodaway County Health Department will be at the Maryville Middle School on **Thursday, May 5th at 9:00 am** to offer a Tdap and/or a MCV4 vaccination to your child.

Nodaway County Health Department is **only** able to bill the following insurance companies: Blue Cross/Blue Shield of Kansas City, Coventry, Medicaid, United, and UMR. Parents will be billed for charges not covered by insurance. Those that are underinsured (insurance does not provide vaccine coverage or has a cap for vaccines) and those with no insurance will not be charged.

If you are interested in your child receiving Tdap vaccine and/or MCV4 vaccine, please 1) complete the health insurance status, 2) sign the **consent below,** 3) complete the **reverse side**, and 4) return in a sealed envelope to Maryville Middle School along with a **front and back copy of child’s insurance card** by **April 5, 2016**.

Enclosed you will find a Vaccine Information Statement for both Tdap and MCV4 vaccines. We encourage parents to review this information ***and*** to be present at the time of the immunization(s).

If you have any additional questions about this vaccination program, please call the Nodaway County Health Department at (660) 562-2755.

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**Eligibility for Tdap and MCV4 vaccine**

Check appropriate box beside vaccine(s) to be given:

Tdap (required)

MCV4 (required)

Check insurance status for your child:

is on Medicaid

has no health insurance

is underinsured

has one of the following insurances

(BCBS KC, Coventry, United, or UMR)

This form must be signed by parent or guardian to verify eligibility and/or signify consent to receive the indicated vaccine(s). The vaccine will not be given without consent at date of vaccination.

I have been given a copy of the Vaccine Information Statement and have read, or had explained to me, the information for the indicated vaccine and I understand the benefits and risks of the vaccines for which I have signed.

Child’s Full Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of parent or guardian Date

**Please complete the following information for your child:**

|  |  |
| --- | --- |
| **DATE OF BIRTH** | **GENDER (circle one)**  MALE FEMALE |
| **RACE (circle all that apply)**  WHITE BLACK ASIAN  AMERICAN INDIAN PACIFIC ISLANDER | **ETHNICITY (circle one)**  HISPANIC NON-HISPANIC |
| **ADDRESS CITY STATE ZIP CODE** | |
| **PHONE NUMBER** | |

**Please answer the following screening questions for your child:**

History of anaphylactic reactions? Yes No

Any serious reactions to vaccines? Yes No

Brain or other nervous system problem? Yes No

Pregnant? Yes No N/A

History of fainting after immunizations? Yes No

Your medical provider is required to maintain a signature log for each Provider-Administered Vaccine dispensed to a Medicare/Insurance Beneficiary “Enrollee”, which acknowledges your receipts of the Provider-Administered Vaccine. By my signature below, I acknowledge that I have received the vaccine as indicated and I authorize my provider to bill and collect from my insurance for the vaccine and related administration fees. I understand that this authorization does not release me from any financial responsibility (co-payments and/or deductibles) required under my plan.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Those participating in this school immunization clinic will be entered into a drawing for 4 FREE St. Joseph Mustangs baseball tickets for a home game of your choice. Drawing to be held on May 9, 2016.**