Consent Form for School Immunization Clinic

Loup Basin Public Health Department is pleased to offer school-based immunization clinics. We accept all major health insurance providers, including Medicaid and Medicare, and offer options for uninsured or underinsured families. To ensure your child can receive their immunizations, please complete both sides of this form and return it to the school.

Student Information:

First Name:	Last Name:	Date of Birth:	Age:	Gender: M / F
Race: ☐White ☐Alaska Native/American Indian ☐African American ☐Other: _____	Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino	Preferred Language: ☐English ☐Spanish ☐Other _____		
Address:	City:	State:	Zip:	County:
Phone Number: (In the event we need to contact you)	Email:			

Insurance Information: (Please attach a copy of insurance or email it to info@lbphd.ne.gov)

Insurance Type: *Please Circle* BCBS UHC Medica Medicaid (Molina / NE Total Care / UHC) Uninsured Underinsured Medicare Other_____	Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other_____	
Subscriber Name: *(If different than above)*	Subscriber Date of Birth:	Street address: *(If different than above)*
Payor ID:	Member ID:	Group #:

Recommended Vaccines by Grade Level:

To easily view your child's immunization record and check which vaccines they are due to receive, scan this QR code. It will direct you to the Nebraska State Immunization Information System (NESIIS), where you can access their complete vaccination history and upcoming recommendations.

If you're unable to access your child's immunization records, you can refer to the immunization schedule guide below. Alternatively, feel free to contact our office at (308) 346-5795, and we'll be happy to provide information on what immunizations your child may need and help you get access to your child's immunization record.

- **4-6 Years / Kindergarten:**
  - DTaP (Diphtheria, Tetanus, Pertussis), Polio, MMR (Measles, Mumps, Rubella), Varicella (Chickenpox)
- **11-13 Years / 7th Grade:**
  - Tdap (Tetanus, Diphtheria, Pertussis), Meningitis (MenACWY), HPV (Human Papillomavirus) – Can be started at age 9
- **16-18 Years / Graduating Seniors / College-bound Students:**
  - HPV (if not previously started/completed), Meningitis (MenACWY) Dose 2, Meningitis B Dose 1
- **Vaccines for Students Behind on Immunizations:**
  - Hepatitis A, Hepatitis B, HIB (Haemophilus influenzae type b), Pneumococcal Conjugate (PCV20), Polio (if not completed), MMR (Measles, Mumps, Rubella, if not completed), Varicella (Chickenpox, if not completed)

Vaccines to be Administered: Please initial by the vaccines you would like your child to receive:

_____DTaP (Diptheria, Tetanus, Pertussis)

_____DTaP/Polio (Kinrix)

_____DTaP/Polio/Hep B (Pediarix)

_____Polio

_____MMR (Measles, Mumps, Rubella)

_____Varicella

_____Tdap (Tetanus, Diphtheria, Pertussis)

_____HPV (Human Papillomavirus)

_____Meningitis ACWY

_____Meningitis B

_____Hib (Haemophilus influenzae type b)

_____Hepatitis A

_____Hepatitis B

_____Pneumococcal

_____Influenza

_____COVID

Loup Basin PUBLIC HEALTH DEPARTMENT

Clinic will be held at
Sargent Public School
May 9th, 2025
11 A.M. – 12:30 P.M.

Please fill out both sides of the form →

Screening Questions for Child/Teen:	Yes	No	Don't Know
Is the child sick today?			
Does the child have allergies to medicine, food, a vaccine component, or latex?			
Has the child had a serious reaction to a vaccine in the past?			
Does the child have a long-term health problem with heart, lungs (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?			
For children aged 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
For babies: Have you ever been told the child had intussusception?			
Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?			
Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?			
Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?			
In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?			
Does the child's parent or sibling have an immune system problem?			
In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?			
Is the child/teen pregnant?			
Has the child received vaccinations in the past 4 weeks?			
Has the child ever felt dizzy or faint before, during, or after a shot?			
Is the child anxious about getting a shot today?			

Consent for Immunization: I GIVE CONSENT to the Loup Basin Public Health Department and its staff to provide the vaccines indicated on the prior page. I have read or had explained to me the Vaccine Information Statement and understand the risks and benefits of these vaccines. I hereby grant permission to Loup Basin Public Health Department to release any pertinent information to the above insurance company upon request and any physician to whom it may be relevant. I understand that Loup Basin Public Health Department will bill any/all the insurance companies I provide.

X

Authorized Signature (client, if 19 or older, or legal guardian) *Today's Date (month/day/year)*

If you have any questions about this form or the vaccines, please contact us.
Sincerely,

Bailey Trotholz, BSN, RN
Immunization Program Coordinator | Public Health Nurse
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