

# MENINGOCOCCAL VACCINE CONSENT FORM

## Information about person to be vaccinated (Please print)

Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_ M \_\_\_\_ F  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_  
 Phone number: \_\_\_\_\_

*(For office use only)*

Clinic: \_\_\_\_\_

### If history of previous dose, check SDIIS

Two doses are recommended for adolescents 11-18 yrs.

- ★ 1st dose at age 11-12, with a booster dose at age 16
- ★ If the 1st dose is given between age 13-15, a booster dose should be given between 16-18
- ★ If 1st dose is given after 16th birthday, booster not needed

The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota. SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information. Immunization records remain confidential, and any person who fails to protect the confidentiality of this information is guilty of a Class 1 misdemeanor. If you choose **NOT** to have your/your child's immunization record shared with other providers you may request a refusal form.

### For a child being vaccinated - check any that apply (Check here if none apply) \_\_\_\_\_

- Enrolled in Medicaid  
 Does not have health insurance  
 American Indian or Alaskan Native  
 Health insurance that DOES NOT pay for vaccines

### Please answer the following questions for the person to be vaccinated:

	Yes	No	Don't Know
1) Is the child sick today?	_____	_____	_____
2) Does the child have allergies to medication, food, a vaccine component, or latex?	_____	_____	_____
3) Has the child ever had a serious reaction to a vaccine in the past?	_____	_____	_____
4) Has the child received a previous dose of meningococcal vaccine?	_____*	_____	_____

\* If previous dose given, please enter date if known: \_\_\_\_\_

I have been provided a copy of and have read or have had explained to me the information about meningococcal vaccine and have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

**Signature** \_\_\_\_\_  
 (Parent or guardian if minor)

**Date** \_\_\_\_\_

### For child being vaccinated at a school-based clinic without parent present:

If you are completing this form for a child to be vaccinated at school and you will not be accompanying him/her, please provide a phone number where you can be reached on the day of the clinic

**Phone** \_\_\_\_\_

### for office use only

	Type	Date/Time	Vaccine Manufacturer	Vaccine Lot number	Route	Site (Circle)	Date of VIS Publication	Full signature of person administering vaccine
Meningococcal	MenACY		Sanofi Pasteur  (Menactra)		IM	L R Deltoid Thigh	3/31/16	

### NOTICE OF PRIVACY PRACTICES - STATE OF SOUTH DAKOTA DEPARTMENT OF HEALTH

If you would like to review the Notice of Privacy Practices, Version I dated 04/14/2003 from the South Dakota Department of Health please refer to website: <http://doh.sd.gov/PDF/HIPAANotice.pdf>