Delaware General Health District
Dedicated to Your Health

School Teen Consent Form

Please Print Clearly

Full School Name		Teacher Name		Grade	

First Name _____ MI _____ Last Name _____ Gender _____ Age _____

Address _____ City _____ State _____ Zip code _____

Phone: _____ Email: _____ Birthdate: ____ (Month) ____ (Day) ____ (Year)

Race : _____ Ethnicity (Please circle one) : ☐ Hispanic/ Latino ☐ Not Hispanic/Latino Preferred Language : _____

INSURANCE COMPANY _____ Member ID _____ Group # _____

Claim Submission Address _____ Primary Insured Name _____

Birthdate _____ Social Security # _____ Relationship to Patient _____

Address (If different from patient) _____

INSURANCE COMPANY _____ Member ID _____ Group # _____

Claim Submission Address _____ Primary Insured Name _____

Birthdate _____ Social Security # _____ Relationship to Patient _____

Address (If different from patient)

NO INSURANCE ☐ My child does not have insurance

Please Answer the following Questions	Yes	No
Is your child sick today?	☐	☐
Does the child have allergies to medications, food, a vaccine component, or latex? If Yes, Please describe:	☐	☐
Has the child had a serious reaction to a vaccine inthe past? If Yes, Please describe:	☐	☐
Does the child have a neurological or brain disease? If Yes, Please describe:	☐	☐
For females: Is your teen pregnant?	☐	☐

PLEASE CHECK MARK WHICH VACCINCE(S) YOU WOULD LIKE YOUR CHILD TO RECEIVE (Child must be at least 11 years old)

☐ Tdap (required for 7th grade)	☐ Meningococcal (required for 7th & 12th grade)	☐ Hepatitis A (recommended)	☐ Human Papillomavirus (recommended)

Will your child be returning to the Delaware General Health District for future doses? ☐ Yes ☐ No

Who is your child's primary doctor?

The Delaware General Health District may keep this record in my child's medical file. DGHD will record what vaccine was given, the date the vaccine was given, the name of the company that made the vaccine, the vaccine lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking recall and recording, unless I request otherwise. I have read or have had explained to me the information sheet about the vaccine. I have had a chance to ask questions, and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request. My medical information will not be shared without an authorization to release information. A copy of the Health Districts Notice of Privacy Practices (HIPAA) will be provided and is also located on our website at delawarehealth.org. I authorize my insurance company to assign the amount payable directly to DGHD.

I understand that I am financially responsible for all the charges that are not covered under my insurance plan. I acknowledge that any co-payment is due and payable on the date services are received.

Parent/Guardian Name (please print clearly): _____ Parent/Guardian DOB: _____

Relationship to Patient: _____

Parent/Guardian Signature: _____ Please Print Off & Sign Date: _____

Office Use Only		Administrative Assistant		VFC	Private	Nurse	
NN Number	Insurance Verified	NN Completed				NN Completed	
		Impact Completed		ACTIVE	INACTIVE	Impact Completed	