METRO CARE CONNECTION
Cedar Rapids Community School District
School-Based Health Centers & Services

2017 Meningitis Vaccine Consent Form

Immunization law now requires Meningitis Vaccinations for all children entering 7th and 12th grade in the 2017-18 school year. Metro Care Connection, CRCSD's school-based Health Clinics will provide these vaccines to those CRCSD students who meet eligibility requirements.

This vaccination program is offered **free** of charge to Cedar Rapids Community School District students **who qualify**.

Please check the box below that applies to your child:

- ☐ Is enrolled in Medicaid (Title 19)
- ☐ Does **NOT** have health insurance
- ☐ Is American Indian or Alaskan Native
- ☐ Has Health Insurance that does not pay for vaccines

Those students who have private insurance can contact their doctor's office or the Linn County Public Health Department. Please call our MCC Program office at 319-558-2481 with questions.

Information about the person to receive the 2017 Meningitis vaccine (please print):

Last Name_____ First Name_____ Middle Name_____

Birthdate_____ Race_____ Gender_____

School_____Grade_____ Age_____

Parent/Guardian Name_____Phone_____Address_____

Physician_____ Insurance_____ Medicaid #_____**(required)**

Consent

I have read and understand the attached Vaccine Information Sheet for Meningitis. I confirm that my child does not have any of the following: a severe allergic reaction to any vaccine in the past, an uncontrolled seizure disorder, a history of Guillian-Barre Syndrome, a history of a severe local reaction to any vaccine, or a history of a progressive neurological disorder within 7 days of receiving any vaccine.

I give permission for my child _____, to receive the Meningitis vaccine at school. I understand I do not need to be present.

Electronic Health Record Notice

I understand that my child's Metro Care Connection health visits will be a part of the MercyCare Service Corporation (MSC) EPIC Electronic Health Record System. Because my child has a medical record within the MercyCare Service Corporation (MSC) EPIC Electronic Health Record System I understand that my child's record may be viewed by MercyCare Service Corporation health care employees and in some situations could be viewed by other healthcare providers outside of Mercy through the EPIC Care Everywhere connection, and I consent to any disclosure consistent with this paragraph.

Privacy Notices

I acknowledge that I have had opportunity to read/receive Metro Care Connection's FERPA Notice of Right's and HIPAA Notice of Privacy Practices. A copy of the full disclosures can be obtained in one of our MCC clinics or accessed on the MCC website http://mcc.cr.k12.ia.us .

Parent/Guardian Signature _____Date _____-

For office use only:

Date administered	Site (circle)	Manufacturer/Lot #	Administered by
	R deltoid .5 cc IM L deltoid .5 cc IM	VIS Date 03/31/2016	JA SG SR

☐ Screened for risk factors