I, ___________________________________________ (relationship to minor) ___________________________________________,

Authorize (the minor's name) ___________________________________________ to be able to come
to the Medical Center circled above for their sports physical that is needed for continuity of care
for the minor listed above.

_______________________________________________  _________________________________
Parent/Guardian Signature                          Witness

_______________________________________________  _________________________________
Date                                               Date  4/2011
Vaccine Update

For the convenience of you and your child we will be offering immunization updates at the sport physical clinics this year!

We look at each child’s immunization record to determine which vaccines are needed. If you have recently moved here or know that your child has had immunizations somewhere else besides the Cass County Health System or Cass County Public Health, we will need those records.

The most common vaccines for 11-18 year old group are Gardasil (HPV), Tdap (Tetanus & Diphtheria with Pertussis), and Meningitis and Hepatitis A vaccines. We recommend you go to the website www.immunize.org and choose the particular “Vaccine Information Sheet” (VIS) you would like to view for more information.

Please note there is an option for Varicella (Chickenpox) vaccine on the following consent form. It may be possible your child has received one of the two required doses.

- IF your child has had the chickenpox disease he/she does NOT need the vaccine.
- IF your child has had one of the two required vaccines and HAS HAD the chickenpox disease, he/she does NOT need the second vaccine.
- IF your child has only had one of the required two doses and has NOT had the disease, we can give that vaccine the day of the sport physical. Please check on the consent form if you would like your child to receive the chickenpox vaccine if needed.

Massena Medical Center has access to no-cost vaccinations through the Vaccines for Children Program. Children 18 and under who have no insurance coverage for vaccinations may access these free vaccines, as well as those of American Indian of Alaskan Native descent. The consent form asks whether you are planning to access the free vaccine, you are requesting we bill your insurance, or if you will be paying for vaccines out of pocket. Please be aware you may be billed for any amount remaining after insurance has considered the claim. You may want to check with your insurance company ahead of time to find out if they will or will not pay for the vaccines. This information must be provided on the consent form for your child to receive immunizations. ****This consent form must be WITH your child the day of immunization.****

Please send this form with the child on the day of immunization.

As always you may have your child receive their immunizations at the Atlantic Medical Center during their normal vaccine walk in hours of:

Monday-Friday ...................... 8:30 a.m. – 11:30 a.m. & 1:00 p.m. – 4:30 p.m.

Saturday ............................... 8:30 a.m. – 11:00 a.m.

We would be happy to answer any of your questions. You may call 712-243-2850 and ask to speak with the immunization nurse. We look forward to hearing from you!
Vaccine Administration Record
2015-2016 School Year Sports Physicals

Record of immunization will be made in the IRIS (Immunization Registry Information Systems), the State of Iowa’s Immunization Registry. Upon your request, we will share information regarding this vacation. “I have received and read the Centers for Disease Controls’ Vaccine Information Statement. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I understand that members of the Atlantic, Anita, and Massena & Griswold Medical Center will bill to the insurance coverage(s) provided below, but I am responsible for and will receive a statement for any amount that stated insurance does not cover. I understand that not filling out this form completely, clearly and correctly may cause incorrect vaccination and billing. I request vaccines to be administrated.”

Choose vaccines to be administered (18yr or younger): I request my child receives...

- [ ] Gardasil (HPV)
- [ ] Hepatitis A
- [ ] Tdap (Tetanus with Pertussis)
- [ ] Meningitis
- [ ] Varicella

<table>
<thead>
<tr>
<th>NAME: (LAST)</th>
<th>(First)</th>
<th>(M.I.)</th>
<th>SCHOOL:</th>
<th>GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CITY:</td>
<td>STATE</td>
<td>ZIP</td>
<td>PARENT NAME &amp; DAYTIME PHONE:</td>
<td></td>
</tr>
</tbody>
</table>

| PHYSICIAN: | PHYSICIAN OFFICE NAME/LOCATION: | PHYSICIAN OFFICE NUMBER: |

Payment Method:
- [ ] I have no insurance or my insurance does not cover immunizations (vaccination provided at no cost, donations welcome)
- [ ] I am American Indian or an Alaskan Native (vaccination provided at no cost, donations welcome)
- [ ] I have private insurance and want the vaccine/s submitted through my insurance plan.

Insurance Policy Holder’s Name: | Policy holder’s DOB: |
Policy Holder’s Address: | Insurance Company Name: |
City: | State: | Zip: |

- [ ] Blue Cross Blue Shield
- [ ] Unite Health Care
- [ ] Cigna
- [ ] Other: ________________

Please Look at your insurance card to complete the information below. You may provide a copy of your insurance card if you prefer.

Insurance Policy Number: | Insurance Group Number: | Parent Signature: | Date: |

For Clinic/Office Use ONLY: Date Vaccine Administered: ______________

Name of School: ATLANTIC | MASSENA | GRISWOLD | ANITA |
- [ ] HPV (90649) | Lot Number: ____________ |
- [ ] Hep A (90633) |
- [ ] Meningitis (90734) | Expiration Date: ____________ |
- [ ] Tdap (90715) |
- [ ] Varicella (90716) | Site of Injection: ____________ |

Signature/Title of Vaccine Administrator: ____________________________
IRIS Entry Done By: ________________ Date: ________________

Bill To:
- [ ] United Health Care
- [ ] Midlands Choice
- [ ] Hawk-i
- [ ] Blue Cross Blue Shield
- [ ] Other: ________________