Meningitis Information Acknowledgement

HEALTH CENTER INFORMATION

REQUIRED SECTION

New/Returning Student (CIRCLE ONE) Spring/Fall Year 20 __ (CIRCLE ONE)

We acknowledge that we have received and have read the information provided by Concordia University, Nebraska regarding Bacterial Meningitis.

Name _____ Student ID J# _____

- ○ We do not want our child to receive the vaccine at this time.
- ○ He/she will be receiving the vaccine before coming to campus. Date received _____
- ○ We would like our child to receive the vaccine on campus.
  (Please complete the following immunization request form and consent form (see reverse). Prepayment is required.)

This is not a mandatory immunization. Please consult with your family physician about the meningitis vaccine.

_____ _____

SIGNATURE OF STUDENT DATE

_____ _____

SIGNATURE OF PARENT (IF UNDER 19, PARENT AND STUDENT MUST SIGN) DATE

Meningitis Vaccination Request

Optional Section

If you are interested in reserving a dose of the vaccine, please print the following information (Prepayment is required):

Name _____ Date of Birth _____

MONTH DAY YEAR

Home Address _____

STREET CITY STATE ZIP

Home Telephone ( )_____ Parent's Name _____

Please note:

- For those who have pre-registered, the vaccine will be offered the first week of classes during Health Center hours. If a student is under 19 years of age, a parent must sign the parental consent form on the reverse.
- We will not be billing insurance companies. Because many insurance companies cover the cost of the vaccine, please check with your company regarding reimbursement.
- The vaccine may be obtained throughout the school year. Please check with the Health Center for more information, as the vaccine is not kept in stock and must be ordered and paid for in advance.
- For any questions or concerns, please contact the Health Center at 800 535 5494, ext. 7224. The Health Center is closed during the summer; however, phone messages are checked regularly.
- Current price for the vaccine is available at **www.cune.edu/healthcenter.**
- Every student who receives the vaccine is encouraged to read the Vaccine Information Statement (VIS) for Meningococcal Vaccines. **www.meningitisvaccine.com.**

Please enclose this form, a check made to Concordia University (if vaccination is chosen) in the envelope marked confidential.

Concordia University Health Center, 800 N. Columbia Avenue, Seward, NE 68434.

STAFF USE ONLY

○ PAID _____INITIALS

○ CASH

○ CHECK

Meningitis Vaccination Consent

REQUIRED SECTION, IF REQUESTING VACCINATION

Name _____ Social Security Number _____

Date of Birth _____ ○ Male ○ Female Age _____ J# _____

If you answer "yes" to any of the following questions, notify the nurse before immunization.

Yes	No	
○	○	Have you had the bacterial meningitis shot before? If yes, when? _____
○	○	Have you ever had a reaction to a bacterial meningitis shot?
○	○	Have you ever had a reaction to a Tetanus, Diphtheria, Pertussis (DPT) shot?
○	○	Are you sick with a fever?
○	○	Do you have a hypersensitivity to dry natural latex rubber?
○	○	Are you or could you be pregnant or are you a nursing mother?
○	○	Are you currently taking any medication(s) (other than birth control)? If yes, specify: _____
○	○	Do you have an immune deficiency? If yes, specify cause: _____
○	○	Have you ever had a severe allergic reaction to anything (e.g., hives, breathing difficulties, shock) requiring emergency treatment?
○	○	Do you have a history of Guillain-Barre Syndrome?

Questions

If you have any questions about the bacterial meningitis disease or the bacterial meningitis vaccination please ask for clarification from the nurse now or call your doctor before requesting the vaccine. **If you have any questions or concerns following vaccination, please contact the Health Center at 800 535 5494, ext. 7224, the local hospital at 402 643 2971, or your physician.**

Consent

I,_____, have been provided with and have read the Vaccine Information Statement (VIS)
PATIENT NAME

for Meningococcal Vaccines (**www.immunize.org/vis/menino6.pdf**) and authorize CUNE to administer the Menactra vaccine. I have been made aware of certain risks that may be associated with this vaccine including the potential for allergic reaction. I understand that I should not receive this vaccine if I am pregnant or breast feeding. I have had the opportunity to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request the vaccine be given to me.

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF WITNESS DATE

If student is less than 19 years old, parent/guardian must sign below:

I give permission for CUNE to administer the Meningococcal Conjugate (Menactra) vaccine to_____
PATIENT NAME

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

STAFF USE ONLY
Meningococcal Conjugate (Menactra)

_____	Left Deltoid Right Deltoid IM	0.5 cc
Lot#/Exp. Date	Site/Route	Dose
_____	_____	_____
Maker	Date Given	Nurse/Clinician Signature
Procedure Code: 90734	Administration Code: 90471	ICD-9 Code: V03.89