

**Mission**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts



**Vision:** To be the Healthiest State in the Nation

**Rick Scott**  
Governor

**John H. Armstrong, MD, FACS**  
State Surgeon General & Secretary

**Authorization to Immunize**

Child's Full Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Child's Social Security Number \_\_\_\_\_

I, \_\_\_\_\_ (Parent or Guardian – Print Your Name), give permission to the Florida Department of Health in Pinellas to give my child immunization(s) (shot) I have been given, read and understand the information about immunizations that are required by 1003 22(3) Fla Stat for my child and about the diseases they protect against I have had a chance to ask questions and have them answered to my satisfaction

**For entry into 7<sup>th</sup> grade:** Tdap (Tetanus-Diphtheria & Pertussis) is required. A Tdap booster is required if two to five years have passed since the last DTP/DTaP/Td immunization

To protect your child from preventable diseases, depending on what is available, the following shots may be offered. Diphtheria & Tetanus (DTaP), Tetanus, Diphtheria & Pertussis (Tdap), Inactivated Polio (IPV), Chickenpox (Varicella VZV), Measles, Mumps & Rubella (MMR), Combination MMR & Varicella (MMR-V), Hepatitis B, vaccines If for any reason shots cannot be given at the school, your child may receive these vaccines at no cost, at any of the five Florida Department of Health in Pinellas centers.

**Unless you tell us in the comment section below, we will give your child the shots we determine are needed by reviewing the available shot record. If the record is incomplete or not correct, that could result in your child getting unnecessary immunizations. This does not mean any additional risk to your child, but we recommend that you update the shot record at least three weeks before we come to the school.**

I give permission for \_\_\_\_\_ (School or Day Care Provider) to release any needed medical information to the Florida Department of Health in Pinellas. This can include my child's medical history, history of allergies and reactions to medicines Please look at the space provided below and write in any medical information you think we need to know.

Has your child had the chicken pox disease?  Yes  No If yes, put month & year \_\_\_\_\_

Does your child have allergies? (Include medications, food & Vaccines)  Yes  No If yes, please list: \_\_\_\_\_

List other medical information and comments: \_\_\_\_\_

If your child has received immunizations since entering school, you must send documents that show this **If the form is not completely filled out and signed, we cannot give the child vaccines unless we can reach you. Please provide phone numbers where we can reach you. Thank you!**

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
Date Parent or Legal Representative Signature

**OPTIONAL SHOTS ONLY**

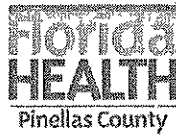
The following free immunizations/shots are recommended for adolescents/teens by the Center for Disease Control & Prevention. If your child has started Human papillomavirus (HPV), Hepatitis A, Meningococcal, the Florida Department of Health in Pinellas will continue the series . Please sign below if you want your child to continue or complete any of the following: Human papillomavirus (HPV), Hepatitis A, Meningococcal.

\_\_\_\_\_  
Date Parent or Legal Representative Signature

**OPTIONAL FLU SHOTS ONLY**

The following Influenza (Flu Shot) is recommended for adolescents/teens by the Centers for Disease Control & Prevention at no cost. Please sign below if you want your child to receive the "Flu" shot (Please see attached sheet for information about Influenza )

\_\_\_\_\_  
Date Parent or Legal Representative Signature



## Insurance Coverage Data

**\*\*The following Questions are for Data Gathering Purpose Only\*\***

1. Is your child covered by Private Insurance?     Yes             No
2. Is your child covered by Healthy Kids?         Yes             No

## Medicaid Coverage Consent

Is your child covered by Medicaid?             No                     Yes

**(If Yes please complete the section below)**

Although all school-based clinic services are available at no cost to you, the Pinellas County Health Department does receive partial financial assistance by billing Medicaid for students with Medicaid coverage. If your child is indeed covered by Medicaid, please sign the following consent.

### **State of Florida Consent for Billing Medicaid**

I hereby assign the Florida Department of Health in Pinellas County all benefits provided under the Medicaid health care plan. The amount of such benefits shall not exceed the medical charges set forth by the Pinellas County Board of Commissioners. All payments under this paragraph are to be made to the Florida Department of Health in Pinellas County. I further authorize the Florida Department of Health in Pinellas County at 205 Dr. M. L. King Jr. Street North, St. Petersburg, FL 33701 and any physician or healthcare provider examining or treating my child to release to any third party for any medical, psychiatric/psychological, alcohol/drug abuse, sexually transmitted disease, tuberculosis, AIDS, HIV, abuse or case management information including information received from other health care providers, concerning diagnosis and treatment for its use in determining a claim for such diagnosis or treatment. This may include any and all information pertaining to payment.

Please check one:             Parent                     Legal Guardian

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_