

SCHOOL IMMUNIZATION CLINIC FORM
DARKE COUNTY DEPARTMENT OF HEALTH
INFORMATION REGARDING PERSON TO RECEIVE VACCINE

Last	First	Middle Initial	Male	Female	Birth date	Age
Address			City		State	Zip
Printed Name of Parent or Guardian				Phone Number		

INSURANCE INFORMATION

Primary Insurance _____ Member ID# _____ Group# _____

Policy Holder Name & Date of Birth _____ / ___ / ___ Relationship to Policy Holder _____

SCHOOL DISTRICT _____

- | | | |
|---|------------------------------|--------------------------|
| | Yes | No |
| 1. Has your child ever had immunizations at the Darke Co. Health Department? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has your child had any recent illness or fever/any ongoing medical problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has your child ever had a reaction to latex or to a previous vaccine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does your child have a history of Guillain-Barre Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Please circle the grade your child will be entering in the Fall. | 7th Grade | Tdap |
| | 12th Grade | Menveo |

I grant permission for this record to be released to medical providers, health departments, schools and others as needed, to transmit the immunization history. Expires six (6) years from date of signature below. I may revoke this Authorization at any time by notifying Darke County Health District in writing, and it will be effective on the date notified. I have read or have had explained to me the Vaccine Information Statements for the below mentioned vaccines. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of this vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request. The presence of my signature also certifies that a copy of HIPAA Privacy Notice was made available. I received a copy of the Vaccine Information Sheet, and I am consenting to have this information entered into the state database. I consent for the above individual to receive below noted immunization(s).

YES **NO**

X _____
Signature of person authorized to make the request. _____
Date

Date Administered	Vaccine Manufacturer	Lot Number	VIS Date	Site of Injection	Dosage	Route	Administrator
3/21/2026	GSK Boostrix	PS4D9 Private CX4HL K4979 VFC	1/31/2025	RD/LD	0.5 ml	IM	CS KH JB EH
3/21/2026	GSK Menveo	T7X22 Private HB333 47G97 VFC	1/31/2025	RD/LD	0.5 ml	IM	CS KH JB EH
3/21/2026	MERCK HPV	Z011258 Private Z002397 VFC	8/06/2021	RD/LD	0.5 ml	IM	CS KH JB EH
3/21/2026	GSK MEN B	DD72H Private DD72H 7433L VFC	1/31/2025	RD/LD	0.5 ml	IM	CS KH JB EH