Platte County Health Department
Serving Platte County Missouri
Consent & Registration Form

Allergies: _____ Reaction _____

Patient Information

Today's Date: _____ Date of Birth: _____ Sex: ☐ Female ☐ Male

Name: (First Last) _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Phone: Home _____ Cell _____

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other

Ethnicity:

- Hispanic/Latino
- Not Hispanic/Latino
- Other

Insurance Information

Insurance: ☐ Private ☐ Medicaid ☐ Uninsured ☐ Underinsured ☐ Native American/Alaskan Native

Medicaid DCN # _____

Private Insurance Information

Name of Primary Health Insurance: _____ Name of Policy Holder: _____

Policy Holder Phone Number: _____ Policy Holder Date of Birth: _____

Policy Holder Address: _____

Policy or Member Numbers: _____ Group Number: _____

Customer Service or Provider Phone Number on back of the Insurance Card: _____

Authorization and Consent

I would like my child to receive:

☐ Meningococcal (Menactra) (Middle and High School)

☐ Tdap (Boostrix) (Middle School only)

☐ Hepatitis A (Havrix Pediatrics)

☐ Human Papillomavirus (Gardasil 9)

☐ Meningococcal B (16 & older)

Personal Financial Responsibility: By signing this form, and in return for the services rendered by the Platte County Health Department (PCHD), I am personally responsible for all fees not paid by any third party on my behalf.

Assignment of Insurance Benefits: I hereby assign all my interest and rights to all insurance benefits otherwise payable to me from any policy to PCHD. I agree that PCHD may disclose any portion of my medical, financial, or personal information to any person or organization requiring such information as a condition of paying, receiving payment for, or justifying payment for my health care or the health care of one for whom I am responsible. I further authorize payment of all insurance benefits, otherwise payable to me, for all treatment provided directly to PCHD.

My signature indicates that I have reviewed a copy of the "Notices of Privacy Practices" and have read the Vaccine Information Statement (VIS) for each vaccine that I am requesting be given to the person named on the form.

Signature of Patient, Parent, or Legal Guardian: _____

Print Name: _____ Date: _____

Relationship to Student (self, parent, or guardian): _____