



Hosting a Vaccine Clinic!

We are excited to partner with you and make this an easily accessible resource for your students and families.

Here is our contact information:

Main Contact: Taylor Young

Email: shsvaccineteam@nationwidechildrens.org

Cell: 614-949-7077

Our goal is to ensure that every child who is behind on vaccines is given the opportunity to take part in this clinic to ensure they can stay in school. As you prepare for your clinic, please utilize us as a resource for you! We are here to help. We look forward to seeing you soon!

What is a vaccine clinic?

A vaccine clinic consists of licensed NCH medical providers and nursing staff that bring all necessary vaccines and supplies to a community site to provide vaccines for prescheduled or walk-up patients. They are not able to provide a complete medical visit or COVID testing, only the requested vaccine. The child's vaccination record will be updated in their personal record, NCH records, and the state immunization registry. Children and families will still be directed to follow up with their primary care doctor when able to complete a full well child visit or for any other healthcare needs.

What is needed from you for a vaccine clinic?

- Indoor space (can be in a vestibule/entry way of a building/classroom)
- 2 6ft tables and chairs (or 3 smaller tables) and trash cans (the number of tables will vary depending on the estimated number of vaccines expected)

What does hosting a clinic look like?

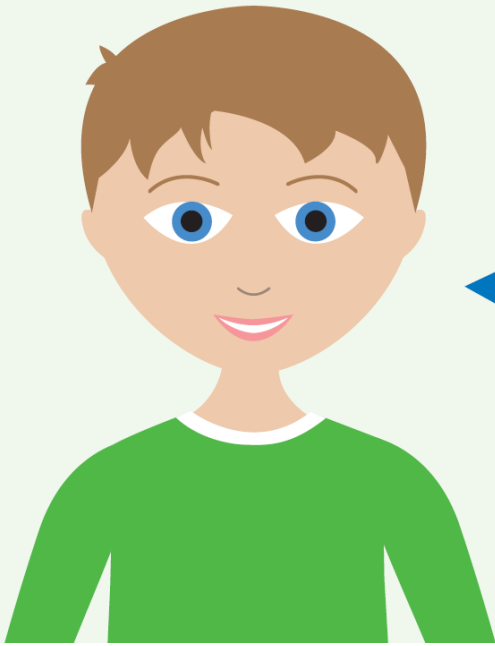
- Identifying students who are non-compliant on vaccines. Walk-ups may be allowed.
- Clinics can range from 2-4 hours
- If parent/guardian is not attending, NCH will need a written consent or will need to call and obtain a verbal consent.
- Identify a plan for getting the child out of class and brought to the clinic

What happens next?

1. Send home a copy of the consent form with parent letter(will be emailed to you) to students who need vaccines
2. Schedule a brief site visit with Taylor Young to see the identified space where the clinic will be held
3. Scan completed consent forms and a copy of the student's shot records to shsvaccineteam@nationwidechildrens.org

To host a clinic or for more information contact Taylor Young at 614-949-7077 or by email at

shsvaccineteam@nationwidechildrens.org



**Immunization
clinic coming to
your child's
school!**

**Nationwide Children's Hospital is coming to
your school to provide immunizations for
your child to stay in school.**

**Complete the attached consent form and return to your
child's school nurse. You will receive a phone call prior to
your child's appointment to discuss medical history and
any concerns.**

*The services provided are not meant to replace your pediatrician or family doctor.
When you have any medical needs, your first call should always be to your
pediatrician or family doctor who knows you best.
No child will be denied care due to inability to pay for services.*



NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.™

Nationwide Children's Hospital School-Based Health Services Vaccine (Immunization) Consent

Office Use Only
Patient ID:

Nationwide Children's Hospital ("NCH") partners with schools to offer vaccines to students. The goal of this program is to help improve the health and well-being of students so they can do their best in school. The purpose of school health services is to provide quality health care in a friendly and familiar school setting at a time that works for the student and family. We are NOT trying to replace your child's primary care doctor.

Student / Family Information (Print all information in ink.)

Student's First & Last Name:	Date of Birth (month/day/year):	Gender:	Race/Ethnicity:	School:	Grade:
Parent/Guardian First & Last Name:	Parent/Guardian Email:	Relationship to Student:		Phone Number:	
Preferred Language:	Street Address:	City:		State:	Zip Code:

Insurance information

- ☐ Medicaid ☐ CareSource ☐ Molina ☐ Other ☐ Private Insurance Plan
☐ NONE, please connect me to NCH financial counselor.

Policyholder's Name _____ Policyholder's Date of Birth _____

Insurance Name _____ Insurance Address _____

Group & ID # _____

All services provided are billed to insurance. If you do not have insurance, NCH will connect you to financial help. All children get medical care if their family can pay or not.

Health History

Medicines Taken:

- ☐ Yes (list below)
☐ No

Allergies

I allow the NCH health care providers to provide the following vaccines for the student named above.

Consent for Vaccinations

I want my child to get **all** vaccines

- ☐ **YES**, I want my child to receive all available vaccines.
☐ **NO**, I only want my child to have the vaccines below (check all that apply).

Required Vaccines for school attendance in Ohio (below). This means Ohio law says your child must have these vaccines to go to school.	Recommended Vaccines (Age appropriate, following the American Academy of Pediatrics vaccination schedule) (Below). This means doctors urge your child to get these vaccines, but they can still go to school without them.
☐ DTaP/TDaP/TD	☐ Influenza (Flu)
☐ Meningococcal	☐ HPV
☐ MMR	☐ Hepatitis A
☐ Varicella	☐ Pneumococcal
☐ Polio	☐ HIB
☐ Hepatitis B	☐ Men B

I agree that I have received information about how to get a Notice of Privacy Practices (explained on the next page). I understand this consent is good for 12 months from the date I sign this form. I understand that I may cancel my consent for treatment at any time by putting in writing I no longer want me/child to have this service. I have read and understand all the information on this form. If I have changes in insurance coverage, I will let NCH know. If there are changes or updates in my child's; health, medicines, or immunizations, I will let NCH and my child's school know. I /my child will receive a Vaccine Record today showing which vaccines were given. I understand I should call (614) 355-2590 option 3 if I have questions or concerns.

X _____
Parent/Guardian Printed name (if student is less than 18)

X _____
Parent/Guardian Signature Date/Time

X _____
(If student 18+) Student Printed Name

X _____
Student Signature Date/Time

Nationwide Children's Hospital

Servicios médicos en la escuela

Consentimiento para vacunarse (inmunizarse)

For internal use only
Patient ID:

Nationwide Children's Hospital ("NCH") colabora con las escuelas para ofrecer vacunas a los estudiantes. El objetivo de este programa es ayudar a mejorar la salud y el bienestar de los estudiantes para que puedan dar lo mejor en la escuela. El propósito de los servicios médicos en la escuela es dar atención médica de calidad en un entorno escolar amigable y familiar, en un horario adecuado para el estudiante y su familia. NO intentamos reemplazar al médico de atención primaria de su hijo.

Información del estudiante/de la familia (escriba toda la información en letra de molde y con tinta).

Nombre y apellido del estudiante:	Fecha de nacimiento (mes/día/año):	Sexo:	Raza/origen étnico:	Escuela:	Grado:
Nombre y apellido del padre/tutor:	Email del padre/tutor:	Relación con el estudiante:	Número de teléfono:		
Idioma preferido:	Dirección:	Ciudad:	Estado:	Código postal:	

Información de seguro

- ☐ Medicaid ☐ CareSource ☐ Molina ☐ Otro ☐ Plan de seguro privado
☐ NINGUNO, comuníqueme con el asesor económico de NCH.

Nombre del asegurado _____ Fecha de nacimiento del asegurado _____

Nombre del seguro _____ Dirección del seguro _____

Grupo y n.º de ID _____

Todos los servicios prestados se le facturan al seguro. Si no tiene seguro, NCH lo comunicará con ayuda económica. Todos los niños reciben atención médica, independientemente de si su familia puede pagarla o no.

Historia médica

Toma medicamentos:

- ☐ Sí (indique abajo)
☐ No

Alergias

Autorizo a los proveedores de atención médica de NCH a dar las siguientes vacunas al estudiante mencionado arriba.

Consentimiento para vacunas

Quiero que mi hijo reciba **todas** las vacunas

- ☐ **SÍ**, quiero que mi hijo reciba todas las vacunas disponibles.
☐ **NO**, solo quiero que mi hijo reciba las vacunas de abajo (marque todo lo que corresponda).

Vacunas obligatorias para asistir a la escuela en Ohio (abajo). Esto significa que la ley de Ohio dice que su hijo debe recibir estas vacunas para ir a la escuela.	Vacunas recomendadas (según la edad, siguiendo el calendario de vacunación de la American Academy of Pediatrics) (Abajo). Esto significa que los médicos recomiendan que su hijo reciba estas vacunas, pero que aún puede ir a la escuela sin ellas.
☐ DTaP/TDaP/TD	☐ influenza (gripe)
☐ meningococo	☐ VPH
☐ MMR	☐ hepatitis A
☐ varicela	☐ neumococo
☐ poliomielitis	☐ HIB
☐ hepatitis B	☐ meningococo B

Reconozco que recibí información sobre cómo obtener un Aviso de prácticas de privacidad (explicado en la página siguiente). Entiendo que este consentimiento es válido por 12 meses a partir de la fecha en que firme este formulario. Entiendo que puedo cancelar mi consentimiento para el tratamiento en cualquier momento poniendo por escrito que ya no quiero recibir/que mi hijo reciba este servicio. Leí y entiendo toda la información en este formulario. Si hay cambios en mi cobertura del seguro, informaré a NCH. Si hay cambios o actualizaciones en la salud, los medicamentos o las vacunas de mi hijo, informaré a NCH y a la escuela de mi hijo. Yo/mi hijo recibiremos hoy un registro de vacunas que mostrará qué vacunas se administraron. Entiendo que debo llamar al (614) 355-2590 opción 3 si tengo preguntas o preocupaciones.

X _____
Nombre en letra de molde del padre/tutor (si el estudiante es menor de 18 años)

X _____
Firma del padre/tutor **Fecha/hora**

X _____
 (Si el estudiante es mayor de 18 años) **Nombre en letra de molde del estudiante**

X _____
Firma del estudiante **Fecha/hora**