Meningococcal Vaccination Consent & Payment Form

Meningococcal Meningitis
Neisseria meningitidis is a bacteria that causes bacterial meningitis. This bacteria can cause swelling of the brain and spinal column which can lead to permanent disabilities including brain damage, hearing loss, seizures, amputation, and even death. Many of the early symptoms of meningitis are similar to a cold or flu, so meningitis can often go undetected until too late. The American College Health Association recommends Meningococcal vaccination for all college-bound students.

Vaccine—Menomune/Menactra
Menomune is a freeze-dried preparation of the group-specific polysaccharide antigens from Neisseria meningitidis, Group A, C, Y and W-135. Menomune is approved for children over 2 years of age. A booster dose is needed at 3-5 years for continued immunity.
Menactra--Meningococcal Groups A,C,Y and W-135 is a sterile, intramuscularly administered polysaccharide Diphtheria Toxoid Conjugate Vaccine. Menactra has been approved for children 11 years old to adult's age 55 years of age. The need for, or timing of, a booster dose of Menactra vaccine has not yet been determined.

Risks and Possible Side Effects
Adverse reactions to meningococcal vaccine are mild and infrequent, consisting of localized erythema (redness) lasting 1-2 days.

Contraindication
Vaccination is generally not recommended for:
1. Children under 2 years of age--Menomune.
2. Children under 11 years of age or adults over 55 years of age--Menactra
3. Pregnant women.
4. Persons with a hypersensitivity to thimerosal--Menomune.
5. Persons with acute illness.

Questions/Concerns
Please call Passport Health at 412-372-4007 and ask to speak to a member of our healthcare staff. If you experience any reactions from the vaccine that are not indicated above, please call your Health care provider.

I have read the above information about Meningococcal Meningitis and the vaccines, and I have had a chance to ask questions. I understand the benefits and risks of the Meningitis vaccination and request that the vaccine be administered to my child.

Information-Person to Receive Vaccine:

Student's Name: ____ Date of Birth: ___________________ Age: _________

Street Address: ____ City: __________________________ State: Zip: ________

Daytime Phone #:______-_______-_______ Evening Phone #: ______-_______-_______

Parent/Guardian's Signature: __________________________________ Student's Signature: __________________________________

Pre-Payment Information:

A Non-refundable payment of $140.00 is due prior to service rendered. This will allow for a proper forecast of vaccine. No check or credit card will be processed until the day vaccine is administered. Please enclose check payable to **Passport Health** and post-date to **10/01/2009** or fill out credit card information.

Visa____ MC ___AmEx ___Exp. Date: ___/___ Card Number ____

Name of person on card:____ Billing Zip-code_______________

Please return consent and payment by *09/17/2009* to:

Passport Health, Williamsburg Place Office Building, 244 Center Road, Suite 102, Monroeville, PA 15146

Payment & consents will be held by Passport Health office until date of vaccination.

For Clinic Use:

Date of Vaccination: _____/_____/_____ Manufacturer & Lot #: ______________________________ Site: SQ ☐Right ☐Left

Administered By: ____________________ Clinic Site: ST. VINCENT, LATROBE Payment received by_________