

Meningitis Vaccination 2006-2007

(734) 477-7229 or (888) 547-7295



Tax ID: 38-2693137
 Procedure Code: 90734
 Administration Code: 90471
 ICD - 9 Code: V03.89
 Vaccination Fee: \$115.00

(please print)

Name _____ Date of Birth _____ (M) or (F) Weight _____
Last Name First Name MI

Local Address _____ Local Telephone No. _____
Street Apt. #

_____ UofM ID # if not UofM student, enter school name
City State Zip

COMPLETE THIS FORM ONLY IF YOU ARE REQUESTING VACCINATION. If you have been immunized against bacterial meningitis (with Menomune or Menactra) in the past 5 years, you should consult your doctor before getting immunized again. Please answer the following questions by checking YES or NO.

- | | |
|---|---|
| <p>1. Have you ever received a vaccination against meningococcal disease?
 <input type="checkbox"/> Yes <input type="checkbox"/> No
 If YES, please indicate month/year: _____</p> <p>2. Do you have any drug allergies or have you had adverse reactions to drugs or other vaccines (especially diphtheria or meningitis vaccine)?
 <input type="checkbox"/> Yes <input type="checkbox"/> No

 If YES, please indicate.
 Drug name: _____
 Vaccine: _____
 Other: _____</p> <p>3. Are you allergic to LATEX?
 <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Are you or could you be pregnant?
 <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>5. Are you currently taking any medication(s) (other than birth control)?
 <input type="checkbox"/> Yes <input type="checkbox"/> No
 If YES, please specify: _____</p> <p>6. Do you currently have an acute illness with a fever of 101°F or higher?
 <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you have a chronic illness?
 <input type="checkbox"/> Yes <input type="checkbox"/> No
 If YES, please describe: _____</p> <p>8. Do you have an immune deficiency?
 <input type="checkbox"/> Yes <input type="checkbox"/> No
 If YES, please indicate the cause:
 <input type="checkbox"/> Disease <input type="checkbox"/> Radiation
 <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Steroids
 <input type="checkbox"/> Other: _____</p> |
|---|---|

PATIENT CONSENT

I have read the information sheet about meningococcal disease and meningitis vaccine. I have had a chance to ask questions which were answered to my satisfaction. The information I have provided above is correct and true to my knowledge. I believe I understand the benefits and risks of meningococcal vaccination and request that the vaccine be given to me or to the person listed below, for whom I am authorized to make this request. I agree that a copy of this form may be forwarded to my school's health service for inclusion in my student file. If my original method of payment is rejected, I agree to be personally responsible for full payment.

Signature of person to receive vaccine (see below if under 18 years old) _____ Date _____

Signature of person authorized to make this request for patient listed above if patient is under 18 years of age _____

I have been provided with a copy of the Notice of Privacy Practice.

FOR CLINIC USE

Intramuscular (IM)
 Deltoid
 Left Right
 Immunization Site

sanofi _____
 Manufacturer & Lot No.

Immunization Provider

To Be Completed by MVN Registrar. Please have your payment ready.

Cash, Check, Credit Card, UM Student Account or CareChoices accepted. MVN does NOT bill other insurances. Patient may seek reimbursement from their insurance. MVN does NOT guarantee reimbursement.

CareChoices Insurance GROUP number: _____

CareChoices Insurance ID number: _____

Credit Card and UM Student Account payments must be completed on separate credit card authorization form.

FEE PAID \$ _____

- Cash
- Check
- Credit Card
- UM Student Acct.
- Other