



## Portage County Combined General Health District

705 Oakwood Street, 2<sup>nd</sup> Floor  
Ravenna, Ohio 44266  
[www.portagehealth.net](http://www.portagehealth.net)



*Joseph Diorio, MPH, MS, RS, Health Commissioner*

Portage County Health District 330-296-9919  
Fax 330-297-3597  
Portage County WIC 330-297-9422  
Columbiana County WIC 330-424-7293

Dear Parent / Guardian:

The Portage County Combined General Health District (PCHD) would like to inform you of vaccine requirements that might affect your child. Per Ohio Revised Code 3313.671 – students must present proof of required vaccinations within 14 days of initial entry or at the beginning of each school year in order to remain in school.

**All students entering the 7<sup>th</sup> grade** will be required to have one dose of the meningococcal ACWY vaccine (also known as MCV4, Menveo, or Menactra) and one dose of Tdap (tetanus, diphtheria, and acellular pertussis).

Other Age-Appropriate vaccine recommendations:

- Human papillomavirus (HPV) – a vaccine series of two doses, 6 months apart; recommended for all 11-12 year old males and females since 2006 to prevent HPV-related cancers later in life.
- Hepatitis A virus – a series of two doses, 6 months apart. Since 2006, this vaccine became a routine recommendation for children greater than 1 year of age to prevent Hepatitis A infection spread through contaminated food and water.
- Varicella (Chickenpox) virus – two doses of this vaccine after the age of 1 year have been recommended since 2006 and 2 doses are required for all students K-10<sup>th</sup> grade.

**All students entering the 12<sup>th</sup> grade** will be required to have a second dose of the meningococcal ACWY (MCV4) vaccine prior to entry. If the first dose of MCV4 was administered on or after the 16<sup>th</sup> birthday, a second dose is not required.

Other Age-Appropriate vaccine recommendations:

- HPV, Hepatitis A or Varicella listed above that need the series begun or completed
- Meningococcal B – a vaccine series of two doses, 1 month apart; recommended for all 16-18 year olds since 2014 to prevent bacterial infection that can attack the brain and spinal cord.

**We will be at Windham Schools on March 16, 2020 from 9am until 12:00 noon.**

If you would like your child to receive vaccine(s) at this clinic, the **Next Steps for Parent / Guardian** are:

1. Review the Portage County Health District HIPAA policy;
2. Review the Vaccine Information Sheets (VIS) for the recommended vaccines;
3. Complete the demographic information and screening questions for your child. Sign and date the form. Please initial "Yes" for all vaccines that you would like your child to receive and initial "No" for the vaccines that you do not want your child to receive or you can mark yes to "Administer age appropriate vaccine after record review" and your child's records will be reviewed and those vaccines deemed appropriate will be administered.
4. Complete the insurance information on the back of the consent form. PCHD does bill most insurance companies. If you do not have insurance or your insurance company is not listed, please call 330-298-4490 for additional information.
5. Return completed consent form to the school nurse by **March 11, 2020.**

These vaccines are also available at:

- The Portage County Combined General Health District located at 705 Oakwood Street, 2<sup>nd</sup> floor, Ravenna. Child immunization clinic hours are every Wednesday, 8:00 am to noon. No appointment necessary.
- Kent City Health Department at 414 E. Main Street, Kent, OH from 3:00 to 5:00 pm the third Wednesday of every month.
- Windham Renaissance Center at 9005 Wilverne Drive, Windham, 4<sup>th</sup> Tuesday every month, 11:00am to 2:00pm.

If you have any questions regarding vaccines or the clinic, please contact me at 330-296-9919, ext. 127.

Sincerely,

*Sherry Halas, RN*

Sherry Halas, BSN, RN  
Public Health Nurse  
[shalas@portagehealth.net](mailto:shalas@portagehealth.net)

# PORTAGE COUNTY COMBINED GENERAL HEALTH DISTRICT

**Information about the person to receive the vaccine(s). Please print.**

NAME: Last First		Birthdate	Sex	Age
ADDRESS:		CITY:		ZIP:
PHONE NUMBER:		Race: <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> Other		
Would you like to receive SMS text message reminders for your vaccine due date? <input type="checkbox"/> No <input type="checkbox"/> Yes If "yes" cell phone provider:				

**Screening Questions:** Which of the following apply to the person receiving the vaccine(s)?

- |   |   |   |
|---|---|---|
| 1. Ill today? .....   | Y | N |
| 2. Have allergies to medications, food or any vaccine?.....                                     | Y | N |
| 3. Serious reaction to a vaccine in the past? .....   | Y | N |
| 4. Received any other vaccines in the past 28 days? .....                                       | Y | N |
| 5. History of seizures, neurological/brain problems? .....                                      | Y | N |
| 6. History of seizures in an immediate family member?.....                                      | Y | N |
| 7. Diagnosed with cancer, leukemia, AIDS, asplenia, or other immune system problems?.....       | Y | N |
| 8. History of diabetes, liver, kidney, heart or lung disease?.....                              | Y | N |
| 9. Received transfusion of blood or blood products or immunoglobulin in past year?.....         | Y | N |
| 10. Taken cortisone/prednisone, other steroids, or anti-cancer medications in past 3 months?... | Y | N |
| 11. Pregnant or chance of becoming pregnant in the next month? .....                            | Y | N |

**Please explain all of the "yes" replies:**

Initial "Yes" for the vaccine(s) you want your child to receive and "No" for the vaccine(s) you do NOT want your child to receive. Please refer to the accompanying instruction letter or contact PCHD with questions or concerns at 330-298-4490.	Yes	No
Administer all age-appropriate vaccine(s) my child needs after reviewing vaccine records		
Hepatitis A		
Human Papillomavirus (HPV)		
Meningococcal ACWY		
Meningococcal B		
Tdap (Tetanus, diphtheria, pertussis)		
Varicella (chicken pox)		

I have answered the above questions to the best of my knowledge. I will receive a copy and read or have read to me the information contained in the Vaccine Information Sheet(s) about the disease(s) and vaccine(s) the patient is going to receive today. I will have a chance to ask questions and have them answered to my satisfaction. I give my consent that the vaccine(s) be given to the patient for whom I am authorized to make this request. I grant permission for this record to be released to other healthcare providers, health departments, schools, daycare centers, community & state immunization registry databases, and others as permitted by law. I have submitted the most up-to-date insurance information. If insurance does not cover the cost of the vaccine(s), I may be billed for services rendered. I have read / seen a copy of the HIPPA policy.

X \_\_\_\_\_  
Signature of Legal Custodian / Client

Date: \_\_\_\_\_

X \_\_\_\_\_, RN

Date: \_\_\_\_\_

Form reviewed / Vaccines administered by

**\*\*\*Please complete insurance information on back\*\*\***

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**PAYMENT - Please select ONE of the following options and provide copy of card if possible:**

☐ **Option 1. Patient is insured. (NOTE: PCHD must bill insurance if patient is insured)**

Primary Insurance (Billed by PCHD\*\*) - Circle one:

ID# \_\_\_\_\_

Aetna	Anthem Blue Cross/Blue Shield	Buckeye	Care Source
Cigna	Medicaid	Medical Mutual	
Molina	Mutual Health	Paramount	Summa Care
United Health Choice Plus	United Health Community Plan		

☐ **Option 2. Patient does not have insurance coverage.**

Pay \$10 (cash or check payable to PCHD) per immunization (shot).

Cash \$ \_\_\_\_\_

Check \$ \_\_\_\_\_

Check # \_\_\_\_\_

**\*\*NOTE-** if you have an insurance policy not listed above, you have the option of paying for the vaccine(s) at the time of service. You will be given a receipt to submit to the insurance company for reimbursement. **Check with your private insurer to verify Portage County Health District is a participating provider and that our services will be covered.** We are not a participating provider for some area plans (examples are, but not limited to, Summa Health employees, University Hospital employees, Cleveland Clinic employees, etc.). Please contact our biller at 330-298-4490 for pricing information, questions or more details. \*\*

## CLINIC/OFFICE USE

Date Administered	Vaccine	Lot Number	Site
			RD / LD
Date Administered	Vaccine	Lot Number	Site
			RD / LD
Date Administered	Vaccine	Lot Number	Site
			RD / LD
Date Administered	Vaccine	Lot Number	Site
			RD / LD

VIS given for all administered vaccines:

	Hep A	7/20/2016
	HPV	10/30/2019
	Men ACW	8/15/2019
	MenB	8/15/2019
	Tdap	2/24/2015
	Varicella	8/15/2019

Updated 12/16/2019

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