MANNING REGIONAL HEALTHCARE CENTER
CLINIC • HOSPITAL • RECOVERY CENTER • PLAZA

1550 6th Street
Manning, Iowa 51455
(712) 655-2072
www.mrhcia.com

Athletic Physical Options

Middle School and High School Age Children

Name:_____

DOB:_____

I wish my child to have

1. **SPORTS PHYSICAL ONLY**
   The fee will be $30.00 and is to be paid at the time of the physical. No insurance will be billed. Cost of immunizations are not included.
2. **ROUTINE YEARLY WELLNESS EXAM**
   The physical will be filed with your insurance, your co-pay/co-insurance, if applicable, is to be paid at the time of the physical.

IMMUNIZATIONS

Please answer the questions below. If your insurance does not cover immunizations, please ask the office personnel for payment options provided by the State of Iowa.

*** **Immunizations will not be administered unless signed by parent*****

Does your insurance cover **required** immunizations? Yes_____ No _____

Does your insurance cover **recommended** immunizations? Yes_____ No_____

By signing below, this indicates that you have verified with your insurance that the following immunizations are covered for payment. If, after the billing process is complete, and immunizations are not covered, you will be responsible.

****Please note that some insurances DO NOT COVER Immunizations******

REQUIRED --- Menactra/ Meningitis - for students entering the 7th and 12th grade

_____Yes, I would like my child immunized if he/she has not already been immunized

_____No, I do not want my child to be immunized for Meningitis

_____My child has had the Meningitis vaccine

REQUIRED --- Adacel/Tetanus & Diphtheria - for students entering the 7th grade

_____Yes, I would like my child immunized if he/she has not already been immunized

_____No, I do not want my child to be immunized for Tetanus and Diphtheria

_____My child has had a recent Adacel vaccine

REQUIRED --- Varicella/Chicken Pox (minimum of 1 injection)

_____Yes, I would like my child immunized if she/he does not meet the requirements by the state of Iowa.

_____No, I do not want my child to be immunized. _____ My child has had the Varicella vaccine

RECOMMENDED --- Gardasil /HPV Series - ages 9 to 26

_____Yes, I would like my child immunized if he/she has not already been immunized

_____No, I do not want my child to be immunized. _____ My child has had the Gardasil vaccine

RECOMMENDED --- Hepatitis A Series - ages 6 months and older

____Yes, I would like my child immunized if she/he does not meet the requirements by the state of Iowa

____No, I do not want my child to be immunized.

If you have any questions regarding immunizations or if your child has any adverse reactions to immunizations administered, please call 712-655-2072

PARENT/GUARDIAN SIGNATURE: _____ DATE:_____