



Parent Consent for County HD Vaccination Clinic

Partner ID: [] Partner Name: []
Clinic ID: [] School Name: []
Patient ID: []

Consent ID: []

VaxCare has partnered with your healthcare provider to provide immunizations. All bills for privately insured patients will come from VaxCare and its physicians.

1 School and Student Information

STUDENT FIRST NAME [] MI [] STUDENT LAST NAME [] AGE [] GRADE [] GENDER: [] M [] F
DATE OF BIRTH (MM+DD+YYYY) [] SCHOOL NAME [] HOME ROOM TEACHER []
ETHNICITY: [] Amer. Indian / Alsk. Native [] Asian [] Black / Afr. Amer. [] Hawaiian / Pac. Islnd. [] Hispanic [] White [] Other []
STREET ADDRESS [] APT/SUITE [] CITY [] STATE [] ZIP []
PARENT/GUARDIAN FIRST NAME [] PARENT/GUARDIAN LAST NAME [] PARENT/GUARDIAN PHONE []

2 Insurance Information (Please fill out completely!)

[] INSURANCE PAY
Please fill in the circle to the left of your primary insurance name.
AARP Secure Horiz [] BCBS Kansas City [] Great West-CIGNA [] Mail Handlers [] Tricare/UHC Military West []
Aetna [] Care Improv Plus [] First Health [] Medicare B [] UMR []
All Savers [] CIGNA [] HealthLink [] Medicare Railroad [] UMWA []
Anthem/BCBS [] Coventry [] Home State/Centene (age 19+) [] Multiplan [] United Healthcare []
BCBS Federal [] Golden Rule [] Humana [] Three Rivers []
PRIMARY INSURANCE NAME [] MEMBER / INSURED ID# [] GROUP ID []
RELATIONSHIP TO THE SUBSCRIBER/INSURED: [] Self [] Spouse [] Dependent
SUBSCRIBER/INSURED FIRST NAME [] SUBSCRIBER/INSURED LAST NAME [] SUBSCRIBER/INSURED DOB (MM+DD+YYYY) [] GENDER: [] M [] F

By signing below, I consent to the use and disclosure of my child's personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed above to VaxCare for the services rendered. I understand I will be responsible for payment for the vaccines provided if my insurance company does not pay.

[] MEDICAID STATE ID # [] NO INSURANCE I have no insurance or Medicaid coverage for my child

By signing below, I request that payment of Medicaid benefits be made on my behalf to [] for any services provided to my child. I give permission to exchange my child's medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents, or other agents needed to determine benefits related to services provided. I agree to participate in treatment plans and to assignment of Medicaid benefits to [] for services rendered.

3 Authorization and Consent

Consent for Use of Protected Health Information & Claims Assignment: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein. Vaccine Authorization: My signature on this form indicates that I have requested that the vaccine indicated below be administered to me by a VaxStation or VaxCare representative. I relieve VaxCare, the VaxCare partner, the administering Nurse and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out of or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association. Neither I nor VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities, or arbitrate any claims as a representative member of a class or in a private attorney general capacity. In the case of occupational exposure, VaxCare has patient's permission for blood testing for patient and employee safety alike. I have read or have had explained to me the information from the Vaccine Information Statement(s) and understand the risks (including adverse reactions) and benefits of the vaccine(s). I understand I will be responsible for payment for the below vaccine(s), these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. Additionally, I understand that if I am a self-pay or no-pay patient receiving services that all funds should be paid at the time of service and not remit to VaxCare. If consenting for another: I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine(s) administration.

SIGNATURE of PARENT or LEGAL GUARDIAN [] DATE []

FOR OFFICE USE ONLY - BLACK INK ONLY

Vaccination Details (Lot number must be recorded. Please adhere label or print clearly.)

[] VFC [] VAXCARE
[] Prefilled Syringe 0.5 mL (36 mths & older)
LOT# []
SITE: [] LD [] RD [] LL [] RL Other []
DELIVERY: [] IM [] ID Other []
ADMINISTRATOR SIGNATURE [] DATE (MM+DD+YYYY) [] ADMINISTRATOR ID []
Nurse/Administrator: I hereby attest by my signature that the patient (or guardian of patient) in question has been provided access to and explained the Vaccine Information Sheets and appropriate Immunization Schedules, and has given verbal and written consent for vaccination(s).

For patients receiving a Fluzone Standard, Fluzone Pediatric, or Fluzone High Dose vaccination: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer “yes” to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to latex, mercury, thimerosal, gelatin, chicken eggs/feathers, or other vaccine components?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had Guillian-Barre syndrome or any other neurological diseases?	<input type="checkbox"/>	<input type="checkbox"/>

