VaxCare

VaxCare has partners with your health care provider to provide immunizations. All bills for immunizations will come from VaxCare and their doctors.

Consent for the Health Department's Vaccine Clinic

PARTNER ID: 116512

Partner Name: Cole County Health Department

CLINIC ID: 1983538

School Name: Helias Catholic High School 2019

CHILD'S DOCTOR:

① Patient Information

FIRST NAME | MIDDLE INITIAL | LAST NAME | AGE | GRADE | GENDER: ☐ M ☐ F

BIRTH DATE (MM-DD-YYYY)

ETHNICITY: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Hispanic ☐ White ☐ Other: _____

ADDRESS | APT/UNIT | CITY | STATE | ZIPCODE

FIRST NAME OF PARENT/GUARDIAN | LAST NAME OF PARENT/GUARDIAN | TELEPHONE

② Contraindication Questions

The following questions will help us determine if there is any reason why we should not give inactivated injectable influenza vaccine to you or your child today. If you answer "yes" to any question, that does not necessarily mean that you (or your child) should not be vaccinated. This only means that additional questions must be asked. If a question is not clear, please have your health care provider explain it to you.

	YES	NO
1. Is the person to be vaccinated sick today?	☐	☐
2. Is the person to be vaccinated allergic to eggs?	☐	☐
3. Is the person to be vaccinated allergic to thimerosal or gelatin?	☐	☐
4. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐
5. Has the person to be vaccinated ever had Guillian-Barre syndrome or any other neurological diseases?	☐	☐

③ Insurance Information (please fill out completely!)

PRIMARY INSURANCE NAME | MEMBER ID | GROUP ID

PATIENTS RELATIONSHIP TO 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 insured 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

④ 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.)

☐ Sanofi Pasteur

☐ GSK

LOT#

EXP. DATE: _____

SITE: ☐ LD ☐ RD ☐ LL ☐ RL

DELIVERY: ☐ IM

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).