CONSENT FOR SERVICES FORM

Complete this form and return it to school.

Every section of this form is required.

Please indicate which vaccines you will be receiving:

☐ Flu ☐ COVID

School ____________________ Grade ________

Patient's Information

Last Name	First Name, Middle Initial	Suffix	Birth Date (month/date/year)	Age	Sex

Complete Mailing Address	City	State	Zip

Demographic Information: Race (circle one)
Native American/Native Alaskan | Black | Asian | Hispanic | White | Unknown/Decline

Ethnicity (circle one)
Hispanic/LatinX | Not Hispanic/LatinX | Unknown/Decline

Parent/Guardian First & Last Name

Primary Phone Number		Email Address

Required Health Insurance Information

Check one:
☐ Private Insurance
☐ Medicaid (ex: Healthy Indiana Plan, Hoosier Care Connect, Hoosier Healthwise)
☐ No Insurance: I certify that the patient is not covered by any health insurance

Insurance Company	Member ID	Group #

Policy Holder's Name	Policy Holder's Date of Birth	Patient SSN

Demographic Information

Number of people in my household:

My current household income is: ☐ below $11,800 ☐ $11,881 - $24,300 ☐ $24,301 - $ 36,450 ☐ $36,451 - $48,600 ☐ $48,601 - $60,750 ☐ $60,751 - $72,900 ☐ over $72,901

Medical Information: please circle Yes or No for ALL questions. Answers are for the person receiving the vaccine.

1. Is the patient allergic to any ingredient in the vaccine? Yes No If yes, please explain:
2. Has the patient ever had a serious reaction to the flu vaccine in the past? Yes No
3. Does the patient have a history of Guillain-Barré syndrome? Yes No
4. Does the patient have any of the following: (mark all that apply)
   ☐ Weakened immune system, cancer, lupus, or HIV/AIDS ☐ A medication that lowers the body's resistance to infection
   ☐ Cochlear implant ☐ Kidney disease/disorder(s) ☐ CSF channel/leak ☐ Neurological disorders
   ☐ Chronic heart disease(s) ☐ Diabetes ☐ Metabolic disorders ☐ Lung disease ☐ Asplenia ☐ Liver disease ☐ Asthma/RAD ☐ Immunocompromised
5. Will the patient be on any antivirals within 3 weeks of getting the flu vaccine? Yes No
6. Is the patient on aspirin therapy or blood thinners? Yes No
7. Is the patient pregnant or could they become pregnant within the next month? Yes No
8. Does the patient live with or have close contact with someone who is immunocompromised? Yes No

All information I have provided on the consent for vaccination is true and correct. I am aware of the HIPAA Notice of Privacy Policy available at supershot.org. I am aware and understand the CDC Vaccine Information Statements for the vaccines the patient will receive today available at https://www.cdc.gov/vaccines/hcp/vis/index.html. I give permission to Super Shot to give the patient the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing, and storage according to Indiana Department of Health policies. By signing below, I agree to the payment option for today's services that I have selected. I understand that if I have asked for a claim to be filed to my insurance company, I am responsible for charges not covered by my insurance plan and agree to pay them in full. I attest to being the patient's legal parent/guardian.

Printed Name of Patient/Guardian ____________________ Signature of Patient/Guardian ____________________ Date ____________

For Official Use Only	Reviewed by: ___________ Date: ___________		Signature of Administrator/VIS provided: ____________ Date: __________					
Vaccine	Manufacture & Lot #	Route/Site	Vaccine	Manufacture & Lot #	Route/Site	Vaccine	Manufacture & Lot #	Route/Site
COVID						FLU		