Akron Children's Hospital
School Based Health Center

Vaccine Consent Form

Only circled vaccines will be offered at this event. See attached vaccine information sheets.
Influenza (Flu) DTaP/Tdap/Td Meningococcal/Men B MMR Varicella Polio
Hepatitis B HPV Hepatitis A Pneumococcal Hib

School Name: _____

PLEASE COMPLETE ALL OF THE INFORMATION BELOW- **Please print using ink** (incomplete forms will not be accepted)

FIRST NAME (of student)		**LAST NAME (of student)**	
Gender: Male Female	**Birthdate: (mo/day/yr)**	**Age**	**Grade**
Home Phone #		**Cell Phone #**	
Address		**City**	**Zip Code** / **State**

The current health care laws require us to bill your insurance company for the vaccine(s). Answers are always confidential. Please fill out the following questions pertaining to your child's Health Insurance.

Parent/Guardian Information

First Name:	Last Name:	Phone #:	Relationship to Student:

REQUIRED INSURANCE INFORMATION (MUST CHECK AN APPROPRIATE BOX)

Insurance Name:	
Insurance Address:	
Subscriber Name/ ID #	**Subscriber DOB:**
MMIS:	**Group #:**

☐ **NONE, please connect me to Children's Financial Counselor**

All services provided are billed to insurance. If you do not have insurance, Children's will connect you to financial assistance.
No child is denied services for inability to pay.

STUDENT HEALTH HISTORY

Allergies: ☐ **YES (list below)** ☐ **NO**

Medications: ☐ **YES (list below)** ☐ **NO**

Other medical problems/health concerns: ☐ **YES (list below)** ☐ **NO**

VACCINATION & HEALTH RELATED QUESTIONS

1. Has your child ever had a life-threatening reaction(s) after a previous dose of any diptheria, tetanus, or pertussis containing vaccine?	YES / NO
2. Has your child ever had a life-threatening allergice reaction after a previous dose of meningococcal ACWY vaccine?	YES / NO
3. Has your child ever had a condition called Guillain Barre Syndrome (GBS) ?	YES / NO
4. Does your child have a blood disorder such as hemophilia?	YES / NO
5. Has your child ever had seizures or another nervous system problem?	YES / NO

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT 330.543.7242

By signing below, I have read and understand the supplemental CDC Vaccine Information Sheets and my signature provides consent for my child to receive the designated vaccines as indicated on this form.. I further agree that I will promptly inform the School-Based Health Center in writing of any changes in my child's physical or dental health and any change in the custody of my child which affects my ability to provide this consent on behalf of my child.

NOTE: In some situations Ohio law permits a minor to consent to medical care without parental consent. For example, parental consent is not required for contraception, pregnancy testing, and prenatal care; sexually transmitted disease testing and diagnosis; HIV testing; treatment of drug and alcohol related conditions; and certain outpatient mental health services. Further, parental consent is not required for the application of first aid treatment or in an emergency.

X_____ X_____ _____
Signature of Parent/Guardian | Printed Name of Parent/Guardian | Date

X_____ X_____ _____
Signature of 2 Witnesses if Verbal Consent *(health care personnel only)* | Printed Name of 2 Witnesses if Verbal Consent *(health care personnel only)* | Date

Akron Children's Hospital

School Based Health Center

SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM

SCHOOL-BASED HEALTH CENTER SERVICES

Throughout this document the use of the term "I" will refer to "I and/or my parents or guardians". The use of the term "me" "myself" or "my" shall refer to the student. The use of "Children's" will refer to Akron Children's Hospital, its physicians, nurses, other health care providers, employees, attending physicians and other physicians, and their assistants or designees.

I and/or my parent(s) or guardian(s) consent to let the physicians, nurses, other health care providers, and employees of Akron Children's Hospital, attending physicians and other physicians, or any of their assistants or designees, do all things that may be needed to diagnose, treat and care for the needs of the above-referenced student. Children's is a teaching hospital and I understand and agree that people who are in training, including, but not limited to, fellows, residents, and students, may assist or participate in my care. I understand and agree that Children's may take photos, video, or audio recording of me and use them for clinical, internal education purposes, legal purposes and quality improvement purposes. I understand and agree that Children's may at its discretion provide certain services to me by remote means called "telehealth". Children's may keep, preserve and use, or properly dispose of any tissue, samples, parts or organs that are taken during operation(s) or procedure(s). I understand that the practice of medicine is not an exact science and that no guarantees have been made about the results of my examination or treatment at Children's.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: I agree to pay all bills for my care, including bills that insurance benefits do not pay. This includes bills for Children's, physicians, or other entities that provided services during my care. I authorize Children's to bill my insurance carrier and request that payments be made directly to Children's. I assign to Children's, my physicians, and other healthcare professionals involved in my care, all of my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, Tricare, any other program for which benefits may be available to pay Children's for the services provided to me, or other payments or judgements. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payer regarding those services. I understand that a financial agreement will be established. I agree to cooperate and provide complete and accurate information as needed to establish my eligibility for such benefits.

PATIENT RIGHTS/PRIVACY INFORMATION: I understand I have the right to take part in decisions about my healthcare and plan for treatment. I have received, read, or had explained to me, and acknowledge receipt of the following documents and/or information, and all my questions have been answered.

Patient Rights and Responsibilities	Advance Directive Information (Patients 18 years and older)
Complaint/Grievance Procedure	Free Hospital Care Information
Health Information Exchange Brochure	"An Important Message from Medicare" (Medicare patients)
HIPAA Notice of Privacy Practices	"An Important Message from Tricare" (Tricare patients)

AUTHORIZATION TO COMMUNICATE: I understand that Children's uses various communication methods including voice calls, computerized calls, computerized text message, email, fax, auto-dialed calls, and pre-recorded messaging for the purposes of sharing clinical/medical results, scheduling appointments, sending appointment reminders, obtaining patient feedback , and communicating/discussing financial responsibilities. By signing this form, I am granting permission to Children's to use all phone numbers and email addresses that I have supplied to contact me regarding this current visit and any future visits. I will be given the opportunity to opt out of future text, email, or phone communications at any time. I understand that my opting out of future text, email or phone communications will not affect, directly or indirectly, my right to receive health care services from Children's.

ALL PATIENTS COVERED BY MEDICAID: I was asked whether any insurance other than Medicaid may cover services provided by Children's. If there is other insurance coverage, I gave that information to Children's.

Privacy Practices

Children's Notice of Privacy Practices is available upon request at any School District building where services are provided. You can also view the Notice of Privacy Practices online at https://www.akronchildrens.org/pages/Privacy-Policy.html. Children's Notice of Privacy Practices describes how Children's may use and disclose you/your child's health information and how you can access you/your child's health information.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

By signing the Authorization For Release of Health Information, you authorize Children's to share you/your child's health information related to the services the School Based Health Center provides to you/your child with the School District, including the School District's nurses, counselors, teachers, and social workers involved in you/your child's care for treatment purposes. Except as provided above and in Children's Notice of Privacy Practices, Children's will not disclose your/your child's health information without your written authorization.

I understand that I do not have to allow release of my child's health information in order for my child to receive treatment, and that I can change my mind at any time and revoke my authorization by writing to the School Based Health Center. However, after a disclosure has been made, I understand that my revocation does not cover information released prior to the revocation. I also understand that health information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by Federal or State privacy law.

Time Period During Which Release of Information is Authorized:

From: Date that form is signed on opposite page
To: Date that student is no longer enrolled in the School