HEALTH HERO
You Keep Them Smart
We Keep Them Healthy

VACCINE CONSENT FORM

Scan QR code for Vaccine Information Statement

School Name: _____

PLEASE COMPLETE ALL OF THE INFORMATION BELOW – Please print using ink (Incomplete forms will not be accepted)

FIRST NAME OF STUDENT		**MIDDLE INITIAL**		**LAST NAME OF STUDENT**			**SUFFIX**		
GENDER: Male (M) Female (F)		**Birth date** (mo/day/yr)		**AGE**		**GRADE**		**HOMEROOM TEACHER**	
ADDRESS								**MOTHER'S MAIDEN NAME**	
CITY		**STATE**		**ZIP CODE**		**PHONE**			
EMAIL									

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.

MY CHILD IS ENROLLED WITH MEDICAID (VFC ELIGIBLE) (mark with an X)		**MY CHILD HAS COMMERCIAL INSURANCE** (NOT VFC ELIGIBLE) (mark with an X)			
Alabama Medicaid	☐	BCBS / All kids	☐	**MEMBER ID POLICY NUMBER**	
		Aetna	☐	**INSURANCE COMPANY NAME**	
		CHAMPVA	☐	**POLICY HOLDER's FIRST NAME**	
		Cigna	☐	**POLICY HOLDER's LAST NAME**	
		Tricare	☐	**BIRTH DATE** (mo/day/yr)	
		UMR- Wausau	☐		
		United Health Care	☐		
		Viva Health Plan	☐	**MY CHILD HAS NO INSURANCE** (VFC ELIGIBLE) (mark with an X)	☐

STOP

Do NOT return this form unless you want your child to be vaccinated.

STUDENT RACE (mark with an X)		**ETHINICITY** (mark with an X)	
African American/Black	☐	**Hispanic**	☐
White	☐	**Non-Hispanic**	☐
Asian	☐		
Hawaiian / Pacific Islander	☐		
Alaskan / Native- American	☐		
Other	☐		

HEALTH QUESTIONS (mark with an X)	**YES**	**NO**
Will this be the first time your child has received a flu vaccine?	☐	☐
Has your child ever had an adverse reaction to any vaccine in the past including Guillain Barre syndrome?	☐	☐
Does your child have a blood disorder such as hemophilia or sickle cell?	☐	☐

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release the school system, HNH Immunizations Inc., MaxVax LLC., Health Heroes and it's affiliates, subsidiaries, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. I acknowledge that I am giving permission for HNH Immunizations Inc. to adjudicate and appeal claims with my insurance providers on my behalf. Clinic dates can be obtained from the school. I understand that the health-related information on this form will be used for insurance billing purposes and your privacy will be protected. I approve the use of my phone number to receive health related information. I request and voluntarily consent for the vaccine to be given and recorded in state registry for the person listed above.

PARENT/GUARDIAN WITH AUTHORITY TO AUTHORIZE VACCINATIONS SIGNATURE			
NAME		**DATE OF SIGNATURE** (mo/day/yr)	
SIGNERS DATE OF BIRTH (mo/day/yr)		**RELATIONSHIP TO CHILD**	

Area for Official Administration Use Only
VIS CDC IIV 08/06/2021
Lot # _____ Exp: _____
Date: _____
_____ LPN/RN/MD

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL US AT 205-609-0268 TO SPEAK TO A REPRESENTATIVE, PLEASE SEE WWW.HEALTHHEROUSA.COM FOR MORE INFORMATION

HNH Immunizations Inc.
326 Prairie Street N.
Union Springs, AL 36089
AL@healthherousa.com
205-609-0268