

## Fall Vaccine Clinic



### Sign up for the **IN-SCHOOL** vaccine clinic in 2 easy steps

**STEP #1:** Fill out and sign the attached  
Parent Letter/ Consent

**STEP #2:** Scan the QR code  
to register online



**Both steps must be done  
to complete the sign-up process.**

For questions call 330-543-7242 or talk to your school nurse clinic staff.

Dear Parent/Guardian,

Akron Children's School Health Services provides the nursing staff within your school district. Our highly trained and experienced nursing and medical staff are here to help keep your child healthy at school. Keeping up with vaccinations is important and we can help make sure your child gets what they need to stay healthy and strong. With your permission, the Influenza (Flu) Vaccine can be administered to your student during the school day. Flu Vaccines are covered by most insurances, and no cost for those who are uninsured. **Please check with your insurance provider to confirm vaccine administration is a covered service at school.** Participation is voluntary. Only students with parent/guardian completed consent form can receive the Flu Vaccine. If we are unable to vaccinate your child at your scheduled vaccine clinic day, your student will have to go to their primary care office or other community resource to get vaccinated.

More information about the Flu vaccine can be found by scanning the QR code.  
Please return this letter AND the attached consent form by: Wednesday September 24th

**Who should receive the Influenza (Flu) Vaccine?**

All students are eligible to receive the Flu vaccine.

I would like my student to receive the below vaccine (please check mark)

	Influenza (FLU)		Flu Information Clinic Date: <u>October 6th</u>	Lot EXP NDC LARM RARM
--	-----------------	------------------------------------------------------------------------------------	----------------------------------------------------	-----------------------------------

Student's Name:	Student's Date of Birth:
Has your child received any vaccines in the past 4 months <b>including</b> Flu, Covid, or any age specific vaccines?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Parent Guardian Signature:	Date: _____
Parent Guardian Name (printed):	
Student's School Building:	
Date of Scheduled Flu Vaccine Clinic:	

**How can my student participate?**

1. Register online by scanning the Flyers QR code
2. Return this form **and** attached completed consent form by Wednesday September 24th.

If you have additional questions, please contact the School Based Health Center at 330-543-7242.

We hope to see your student in the clinic!

SHS District Nurse Use Only:

ImpactSIS Reviewed for Accuracy

School Records Reviewed for Accuracy

District Nurse: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

(Place patient label here if blank)



### 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 (MCV4) Meningitis 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)	
Birthdate: (mo/day/yr)		Age	Grade
PARENT/GUARDIAN INFORMATION			
First Name:		Last Name:	Phone #:
			Relationship to Student:
VACCINATION & HEALTH RELATED QUESTIONS			
1. Has your child ever had a life-threatening reaction to a vaccine of any kind?			YES / NO
2. Has your child ever had a condition called Guillain Barre Syndrome (GBS)?			YES / NO
3. Does your child have blood disorder such as hemophilia?			YES / NO
4. 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 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.			

Printed Name of Parent/Legal Guardian \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Printed Name of Witness #1 to Signature if Verbal Consent (health care personnel only) \_\_\_\_\_

Signature of Witness #1 \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Printed Name of Witness #2 to Signature if Verbal Consent (health care personnel only) \_\_\_\_\_

Signature of Witness #2 \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

#### 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 judgments. 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 | Health Information Exchange                | Advance Directive Information (Patients 18 yrs and older) | *An Important Message from Medicare* (Medicare patients) |
| Complaint/Grievance Procedure       | Brochure HIPAA Notice of Privacy Practices | Free Hospital Care Information                            | *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 your/your child's health information and how you can access your/your child's health information.



FM00592  
Rev. 2/21/25