



# Parent Consent for \_\_\_\_\_ Health Department Vaccination Clinic

VaxCare has partnered with your healthcare provider to provide immunizations.  
All bills for privately insured patients will come from VaxCare and its physicians.

|             |                      |               |                      |
|-------------|----------------------|---------------|----------------------|
| Partner ID: | <input type="text"/> | Partner Name: | <input type="text"/> |
| Clinic ID:  | <input type="text"/> | School Name:  | <input type="text"/> |
| Patient ID: | <input type="text"/> |               |                      |

Consent ID: \_\_\_\_\_

## ① School and Student Information

|                                                                                                                                                                                                                                                                                            |    |                           |                       |       |                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|---------------------------|-----------------------|-------|---------------------------------------------------------------|
| STUDENT FIRST NAME                                                                                                                                                                                                                                                                         | MI | STUDENT LAST NAME         | AGE                   | GRADE | GENDER: <input type="checkbox"/> M <input type="checkbox"/> F |
| DATE OF BIRTH (MM-DD-YYYY)                                                                                                                                                                                                                                                                 |    | SCHOOL NAME               | HOME ROOM TEACHER     |       |                                                               |
| ETHNICITY: <input type="checkbox"/> Amer. Indian / Alsk. Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / Afr. Amer. <input type="checkbox"/> Hawaiian / Pac. Islnd. <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other |    | STREET ADDRESS            |                       |       | APT/SUITE                                                     |
| PARENT/GUARDIAN FIRST NAME                                                                                                                                                                                                                                                                 |    | PARENT/GUARDIAN LAST NAME | PARENT/GUARDIAN PHONE |       |                                                               |

## ② Insurance Information (Please fill out completely!)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         |                                        |                                                       |                                                                                                   |                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> INSURANCE PAY                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="radio"/> AARP Secure Horiz | <input type="radio"/> BCBS Kansas City | <input type="radio"/> Great West-CIGNA                | <input type="radio"/> Mail Handlers                                                               | <input type="radio"/> Tricare/UHC Military West |
| Please fill in the circle to the left of your primary insurance name.                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="radio"/> Aetna             | <input type="radio"/> Care Improv Plus | <input type="radio"/> First Health                    | <input type="radio"/> Medicare B                                                                  | <input type="radio"/> UMR                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="radio"/> All Savers        | <input type="radio"/> CIGNA            | <input type="radio"/> HealthLink                      | <input type="radio"/> Medicare Railroad                                                           | <input type="radio"/> UMWMA                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="radio"/> Anthem/BCBS       | <input type="radio"/> Coventry         | <input type="radio"/> Home State/Centene (age 19+)    | <input type="radio"/> Multiplan                                                                   | <input type="radio"/> United Healthcare         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="radio"/> BCBS Federal      | <input type="radio"/> Golden Rule      | <input type="radio"/> Humana                          | <input type="radio"/> Three Rivers                                                                |                                                 |
| PRIMARY INSURANCE NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                         | MEMBER / INSURED ID#                   |                                                       | GROUP ID                                                                                          |                                                 |
| RELATIONSHIP TO THE SUBSCRIBER/INSURED: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent                                                                                                                                                                                                                                                                                                                                                                  |                                         |                                        |                                                       |                                                                                                   |                                                 |
| SUBSCRIBER/INSURED FIRST NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         | SUBSCRIBER/INSURED LAST NAME           |                                                       | SUBSCRIBER/INSURED DOB (MM-DD-YYYY) GENDER: <input type="checkbox"/> M <input type="checkbox"/> 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 insurer 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.                                                                                                                                   |                                         |                                        |                                                       |                                                                                                   |                                                 |
| <input type="checkbox"/> MEDICAID STATE ID #                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> NO INSURANCE   |                                        | I have no insurance or Medicaid coverage for my child |                                                                                                   |                                                 |
| By signing below, I request that payment of Medicaid benefits be made on my behalf to _____ for any services provided to my child. I give _____ permission to exchange my child's medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents, or other agents needed to determine benefits related to services provided. I agree to participate in treatment plans and to assignment of Medicaid benefits to _____ for services rendered. |                                         |                                        |                                                       |                                                                                                   |                                                 |

## ③ 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 | <input type="text"/> | DATE | <input type="text"/> |
|---------------------------------------|----------------------|------|----------------------|

## FOR OFFICE USE ONLY - BLACK INK ONLY

Vaccination Details (Lot number must be recorded. Please adhere label or print clearly.)

|                                                                        |                                  |                   |                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------|----------------------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> VFC                                           | <input type="checkbox"/> VAXCARE | LOT#              | SITE: <input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> LL <input type="checkbox"/> RL Other _____                                                                                                                                                        |
| <input type="checkbox"/> Prefilled Syringe<br>0.5 mL (36 mths & older) |                                  | DATE (MM-DD-YYYY) | DELIVERY: <input type="checkbox"/> IM <input type="checkbox"/> ID Other _____                                                                                                                                                                                                            |
| ADMINISTRATOR SIGNATURE                                                |                                  | 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). |

**For patients receiving a Fluzone Standard, Fluzone Pediatric, or Fluzone High Dose vaccination:** The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

|                                                                                                                                                 | YES                      | NO                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Is the person to be vaccinated sick today?                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the person to be vaccinated have an allergy to latex, mercury, thimerosal, gelatin, chicken eggs/feathers, or other vaccine components? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the person to be vaccinated ever had Guillian-Barre syndrome or any other neurological diseases?                                         | <input type="checkbox"/> | <input type="checkbox"/> |

**Additional Information:** Shared clinical decision-making (SCDM) is recommended for certain vaccines in specific populations. This means vaccination decisions are made jointly by the patient and healthcare provider based on individual health status, risk factors, and preferences.

*Influenza (Flu): Annual influenza vaccination continues to be recommended by the CDC. Patients are encouraged to discuss any health concerns, contraindications, or questions with their healthcare provider.*

Parent/Patient Signature: \_\_\_\_\_

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

