vaxcare Vaccine Consent Form

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

Clinic Info

Partner / Clinic Name

Date of Service __ / __ / ____

Payment & Patient Info

Patient Name

Date of Birth __ / __ / ____

Gender

Phone ___ - ___ - ____

Address

Social Security # ___ - __ - ____

Payer Name

Member ID

Group ID

Insured Name

Insured Date of Birth __ / __ / ____

Ins. Gender

Relation to Insured

Payment Type

Credit Card Number

Expiration Date __ / ____

CVV Code

Notes

Check Out Doses

Check out and scan all ordered doses on the VaxCare Hub by the end of day.

Vaccine	Lot #	Site (LD LL RD RL)	Route (IM SQ IN PO)	Vaccine	Lot #	Site (LD LL RD RL)	Route (IM SQ IN PO)
		☐ ☐ ☐ ☐	☐ ☐ ☐ ☐			☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
		☐ ☐ ☐ ☐	☐ ☐ ☐ ☐			☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
		☐ ☐ ☐ ☐	☐ ☐ ☐ ☐			☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

Administrator Name

Administrator Signature

Administration Date __ / __ / ____

Collect 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.

Patient Signature

Date __ / __ / ____

School Immunization Clinic Parental Consent Form

School Name _____ Clinic Date _____

In order for your child to obtain the adolescent vaccinations during this school based clinic, you must
1. **Complete** both sides of this form, 2. **Provide** previous vaccination records, and 3. **Sign & Date** this form.

A. INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT)

Student's Name Last _____ First _____ Middle _____

Student's Birth Date _____ Age _____ Gender ☐ *Male* ☐ *Female*

Parent/Guardian Name Last _____ First _____ Relationship _____

Student's Address _____ City _____ Zip Code _____

B. VACCINE ELIGIBILITY SCREENING (PLEASE CHECK APPROPRIATE BOX)

☐ **Medicaid** A child, 0 through 18 years of age, who has Medicaid as primary insurance.

☐ **American Indian/Alaskan Native** A child, 0 through 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance.

☐ **No Health Insurance** A child, 0 through 18 years of age, who does not have health insurance.

☐ **Insurance Does Not Cover Vaccines (Underinsured)** A child, 0 through 18 years of age, who has commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (these children are categorized as underinsured for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured).

☐ **Fully Insured** A child, 0 through 18 years of age, who has health insurance which provides coverage for vaccines. If primary insurance denies the claim and Medicaid is a secondary insurance, the healthcare provider will make the adjustment and bill Medicaid.

C. VACCINE HEALTH SCREENING (CIRCLE YES OR NO)

Please answer all questions about the student who will be receiving the vaccine(s). Answers will determine whether the student can be vaccinated at this time.

Yes ☐ No ☐ 1. Does the student have any allergies to medication, foods, or any vaccines?
If yes, please explain _____

Yes ☐ No ☐ 2. Has the student had a serious reaction to a vaccine in the past?

Yes ☐ No ☐ 3. Has the student had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?

Yes ☐ No ☐ 4. Has the student had a seizure, brain or other nervous system problem, including Guillain-Barré Syndrome?

Yes ☐ No ☐ 5. Does the student have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?

Yes ☐ No ☐ 6. Has the student taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?

Yes ☐ No ☐ 7. Has the student received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?

Yes ☐ No ☐ 8. Is the student pregnant or is there a chance she could become pregnant during the next month? *If yes, student should not receive MMR, HPV, or varicella vaccines.*

Yes ☐ No ☐ 9. Has the student received vaccinations in the past four (4) weeks?
If yes, please list vaccines _____

D. CONSENT TO VACCINATE

I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for the each vaccine my child will be receiving. I have had a chance to ask questions and fully understand the benefits and risks of each of the indicated vaccines and ask the following vaccines be given to my child on the scheduled school clinic date (check all that apply):

☐ Meningococcal ACWY (MCV4)
☐ Meningococcal Serogroup B (MenB)
☐ Polio
☐ Hepatitis A
☐ Tetanus, diphtheria, acellular pertussis (Tdap)
☐ Measles, mumps, rubella (MMR)
☐ Diphtheria, tetanus, acellular pertussis (DTaP)
☐ Varicella (Chickenpox)
☐ Hepatitis B
☐ HPV

School Immunization Clinic Parental Consent Form

I give permission to the Lake County County Health Department, the Indiana State Department of Health, and/or their designees to vaccinate the student named on this form.

Signature of Parent/Guardian _____ Date _____

E. To Be Completed by Person Administering Vaccine

Vaccine	Manufacturer/Lot Number/ Expiration Date	Signature of Vaccinator	Site	Route	Date of VIS
MCV4			Left or Right Deltoid	IM	
Tdap			Left or Right Deltoid	IM	
Varicella			Left or Right Arm	SC	
MMR			Left or Right Arm	SC	
IPV			Left or Right Arm	SC IM (Please circle)	
Hep B			Left or Right Deltoid	IM	
Hep A			Left or Right Deltoid	IM	
DTaP			Left or Right Deltoid	IM	
HPV9			Left or Right Deltoid	IM	
MenB			Left or Right Deltoid	IM	

The HPV and MenB vaccines are not school requirements. However, it is a requirement of school-based clinics enrolled in the VFC program to offer the HPV and MenB vaccines to both boys and girls.

Entered into CHIRP by _____ Date _____