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	/axCare	
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Parent Consent For Independence City Health Department

Partner Name: Partner ID: 116554

INDEPENDENCE CITY

(Tdap & Meningococcal)

Consent ID:

cova a cardomas	Clinia ID	4404045	Independence City Health Department			
s partnered with your healthcare provider to	Clinic ID:	1681045	School Name:			
munizations. privately insured patients will come from	Patient ID:	,M (437)23	Nowlin			

VaxCare and its physician	s.									
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(2) Insurance	e Informati	ion (Please fill	out com	pletely!)						SALES OF
INSURANCE	F O	AARP Secure Ho	oriz O	BCBS Kansas City	○ Great	West-CIGNA		Mail Handlers	○ Tricare/	JHC Military West
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By signing below, I cons I will be responsible for	ent to the use and dis payment for the vaco	closure of my child's per tines provided if my insu	ional health inf rance company	ormation for the purpose of does not pay.	health care oper	ations, along with the assig	gnment of all pa	ayments from the insurer listed ab	ove to VaxCare for the	services rendered. Lunderstand
MEDICAID						NO	17-18-	I have no insurance or Me	dicaid coverage f	or my child
STATE ID #		1 1 1		1 1 1	Stability	The state of the s	RANCE	ad Idag vaccion	viacas Eli	
By signing below, I requ or other confidential in	uest that payment of formation as necessa	Medicaid benefits be ma ry to the Centers for Me	de on my beha dicare and Med	If to Indepdendence City He dicaid Services (CMS), its ago	alth Department ents, or other ag	for any services provided t ents needed to determine	to my child. I g benefits relate	ive Indepdendence City Health De ed to services provided. I agree to	epartment permission o participate in treatm	to exchange my child's medical ent plans and to assignment of
Medicaid benefits Indep	pdendence City Healt	h Department for service	es rendered.	NAMES OF THE OWNER, OF THE	Maria Const	A DESCRIPTION OF STA	55000	SAN CONTRACTOR		
	cation and (I I all to to an all an	forth annual florible and
	hlennest of all	naumant from the incur	r listed above to	a Vay Care accordated with th	a cornigae contar	nniated herein. Vaccine Air	ithorization: Mu	use and disclosure of my person signature on this form indicates	nat i nave requested t	nat the vaccine indicated below
be administered to me	by a VaxStation or Va	Care representative. I re	lieve VaxCare, t	the VaxCare partner, the adm	ninistering Nurse	e and personnel of any liab nor action shall be determ	ollity for any rea sined solely on a	actions that should occur. I uncon an individual basis through arbitra	ortionally and irrevoca	th Commercial Arbitration Rules
of the American Achites	tion Accordation Mai	that I nor VavCara chall !	a entitled to in	in or consolidate claims in a	rhitration by or a	nainst other individuals or	r entities, or arb	bitrate any claims as a represental d to me the information from the	ive member of a class	or in a private attorney deneral
unseine adition 2/21/20	116 For Transpecing	adition 2/24/2015 and	understand the	ricke (including adverse rea	ctions) and bene	fits of the vaccine(s). Lund	lerstand I will b	e responsible for payment for the	below vaccine(s), the	se services are not free, and that
nonpayment by the insu	urance company or pa	atient will result in colle thority, based on my rel	ctions for the ar ationship to the	nount due. Additionally, 1 ui : individual indicated above,	nderstand that if to consent to th	l am a self-pay or no-pay ¡ is vaccine(s) administratio	patient receivin n.	ng services that all funds should b	e paid at the time of s	ervice and not remit to vaxCare.
SIGNATURE	_	,	•							
or LEGAL C	_							DATE		1 1 1
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VACCINE USED: PRODUCTS ADM		VFC Adacel/Boo	VAXCA	Menactra						
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Product Name:

Product Name:

ADMINISTRATOR ID

LOT#

Ind.City.HD.Consent.(Tdap&Menin).121316 All rights reserved - VaxCare Corp. Printed in the USA

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DELIVERY: M SQ PO IN Other_

DELIVERY: IM SQ PO IN Other

DATE (MM®DD®YYYY)

Product Name:

Product Name:

LOT#

LOT#

ADMINISTRATOR SIGNATURE

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). (888) 829-8550 www.vaxcare.com

LD RD LL RL Other_

LD RD LL RL Other

DELIVERY: IM SQ PO IN Other

DELIVERY: MIM SQ PO NO Other

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean 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 child sick today?		
Does the child have allergies to medications, food, a vaccine component, or latex? Please explain:		
3. Has the child had a serious reaction to a vaccine in the past? Please explain:		
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy? Please explain:		
5. Has the person to be vaccinated ever had Guillian-Barre syndrome or any other neurological diseases? Please explain:		
6. Has the child had a seizure; has the child had brain or other nervous system problems? Please explain the condition or seizure:		
7. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?		
8. Has the child received Meningococcal vaccine in the past? If so, when?	- 🗆	
9. Has the child received Tdap vaccine in the past? If so, when?	_ 🗇	П

