



Parent Consent For Independence City Health Department

INDEPENDENCE CITY (Meningococcal)

Partner ID: 116554

Partner Name: Independence City Health Department

Clinic ID: 1681047

School Name:

Patient ID:

Chrisman

Consent ID:

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

1 School and Student Information

STUDENT FIRST NAME, MI, STUDENT LAST NAME, AGE, GRADE, GENDER, DATE OF BIRTH, SCHOOL NAME, HOME ROOM TEACHER, ETHNICITY, STREET ADDRESS, APT/SUITE, CITY, STATE, ZIP, PARENT/GUARDIAN FIRST NAME, PARENT/GUARDIAN LAST NAME, PARENT/GUARDIAN PHONE

2 Insurance Information (Please fill out completely!)

INSURANCE PAY, AARP Secure Horiz, BCBS Kansas City, Great West-CIGNA, Mail Handlers, Tricare/UHC Military West, Aetna, Care Improv Plus, First Health, Medicare B, UMR, All Savers, CIGNA, HealthLink, Medicare Railroad, UMW, Anthem/BCBS, Coventry, Home State/Centene (age 19+), Multiplan, United Healthcare, BCBS Federal, Golden Rule, Humana, Three Rivers

PRIMARY INSURANCE NAME, MEMBER / INSURED ID#, GROUP ID, RELATIONSHIP TO THE SUBSCRIBER/INSURED, SUBSCRIBER/INSURED FIRST NAME, SUBSCRIBER/INSURED LAST NAME, SUBSCRIBER/INSURED DOB, GENDER

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.

MEDICAID STATE ID #, 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 Independence City Health Department for any services provided to my child. I give Independence City Health Department 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 Independence City Health Department 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.

SIGNATURE of PARENT or LEGAL GUARDIAN, DATE

FOR OFFICE USE ONLY - BLACK INK ONLY

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

VACCINE USED: VFC, VAXCARE, PRODUCTS ADMINISTERED: Menactra

Table with 4 columns: Product Name, LOT#, SITE, DELIVERY. Includes rows for LD, RD, LL, RL, IM, SQ, PO, IN.

ADMINISTRATOR SIGNATURE, DATE (MM/DD/YYYY), 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 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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex? Please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past? Please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
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: _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the person to be vaccinated ever had Guillian-Barre syndrome or any other neurological diseases? Please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child had a seizure; has the child had brain or other nervous system problems? Please explain the condition or seizure: _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the child received Meningococcal vaccine in the past? If so, when? _____	<input type="checkbox"/>	<input type="checkbox"/>

