

Parent Consent For Independence City Health Department

Partner Name: Partner ID: 116554 Independence City Health Department Clinic ID: 1681047

School Name:

INDEPENDENCE CITY (Meningococcal)

Consent ID:

rovide immunizations. Il bills for privately insure	patients will come from	ient ID:	Chrisn	nan						
axCare and its physicians.										
1 School ar	nd Student Information									
STUDENT FIRST I	NAME	MI STUDENT LA	ST NAME			AGE	GRADE	GENDER: M		
DATE OF BIRTH (MM*DD*YYYY) SCHOOL NAME HOME ROOM TEACHER										
BAIL OF BIRTH	• SCI	I I I I I I I I I I I I I I I I I I I			THE WILL HOUSE	I I I				
ETHNICITY:	Amer. Indian / Alsk. Native	Asian Black / Afr. Amer.	Hawaii	an / Pac. Islnd.	Hispanic Wh	ite Other				
STREET ADDRESS APT/SUITE CITY STATE ZIP										
			1 1		1 1 1 1	1 1 1 1				
PARENT/GUARDI	AN FIRST NAME	PARENT/GUARDIAN LA	AST NAME			PARENT/GUA	RDIAN PHONE			
			1 1 1					1		
2 Insurance	e Information (Please fill	l out completely!)								
INSURANCE PAY	AARP Secure Ho	oriz BCBS Kansas City	Great	West-CIGNA	Mail	Handlers	○ Tricare/UF	IC Military West		
	Aetna	Care Improv Plus	First I	lealth	Med	icare B	UMR			
Please fill in the circle to the left of your primary	All Savers	CIGNA	Healt	nLink	Med	icare Railroad	UMWA			
	O Anthem/BCBS	Coventry	Home	State/Centene (ag	ge 19+) Mult	tiplan	O United He	althcare		
insurance name.	○ BCBS Federal	O Golden Rule	Huma	ina	○ Thre	e Rivers				
PRIMARY INSUR	ANCE NAME	MEMBER /	INSURED II	D#			GROUP ID			
DEL ATIONICI II D.T.	O THE CHRECEIPED (INCHEE	e: Self Spouse	Depen	dent						
	O THE SUBSCRIBER/INSURED SURED FIRST NAME	SUBSCRIBER/II			SU	JBSCRIBER/INSU	RED DOB (MM*DD*)	YYYY) GENDER:		
,								M		
By signing below. I conse	nt to the use and disclosure of my child's per	sonal health information for the purpose of	health care opera	itions, along with the assign	nment of all payments fron	n the insurer listed ab	ove to VaxCare for the ser	F vices rendered. I understand		
I will be responsible for p	payment for the vaccines provided if my insu	rrance company does not pay.								
MEDICAID STATE ID # I have no insurance or Medicaid coverage for my child										
or other confidential info	est that payment of Medicaid benefits be ma ormation as necessary to the Centers for Me dendence City Health Department for servio	edicare and Medicaid Services (CMS), its ag	ealth Department ents, or other ag	for any services provided to ents needed to determine b	o my child. I give Indepder benefits related to services	ndence City Health De s provided. I agree to	participate in treatment	plans and to assignment of		
	ation and Consent					- Em				
operations, along with the administered to me b jury, to the maximum ex of the American Arbitrat capacity. In the case of o vaccine, edition 3/31/20 company or patient will	cted Health Information & Claims Assignm The assignment of all payment from the insury The available of a law for any claim or action a The association. Neither I nor VaxCare shall i Coupational exposure, VaxCare has patient's To and understand the risks (including adv To and understand the risks (including adv To and understand the risks) To and understand the risks (including adv To and understand the risks)	er listed above to VaxCare associated with the elieve VaxCare, the VaxCare partner, the ad urising out of or related to this service, and the be entitled to join or consolidate claims in a permission for blood testing for patient an erse reactions) and benefits of the vaccine litionally, I understand that if I am a self-pa	ne services conter ministering Nurse hat any such clain orbitration by or a od employee safe! (s). I understand y or no-pay patie!	nplated herein. Vaccine Autl and personnel of any liabil n or action shall be determin gainst other individuals or y alike. I have read or have I will be responsible for pa	horization: My signature or lity for any reactions that s ned solely on an individual entities, or arbitrate any cl had explained to me the i yment for the below yacci	n this form indicates t should occur. I uncond I basis through arbitra aims as a representat information from the ine(s), these services	that I have requested that ditionally and irrevocably tion in accordance with C ive member of a class or i Vaccine Information Stat are not free, and that no	the vaccine indicated below waive any right to a trial by iommercial Arbitration Rules in a private attorney general ement(s) for Meningococcal onpayment by the insurance		
SIGNATURE of	of PARENT	nea above, to consent to this vaccine(s) au	ministration.							
or LEGAL G		····· FOR OFFICE	LICE ON	V - DI ACK INI	K ONLY	DATE				
Vaccination	Details (Lot number m									
VACCINE USED:	VFC	VAXCARE								
PRODUCTS ADMINISTERED: Menactra										
	LOT#	SITE: LD RD LL R	L Other	Product Name:	LOT#	s	ITE: LD RD	LL RL Other		
		DELIVERY- DIM DSO DEO DIN	Other				DELIVERY: MIM SO	PO IN Other		

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LD RD LL RL Other

LD RD LL RL Other_ DELIVERY: IM SQ PO IN Other_

DELIVERY: IM SQ PO IN Other_

DATE (MM®DD®YYYY)

Product Name:

Product Name:

ADMINISTRATOR ID

LOT#

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

SITE:

LD RD LL RL Other_

LD RD LL RL Other_

DELIVERY: IM SQ PO IN Other_

DELIVERY: IM SQ PO IN 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?		
2. 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?		

