VaxCare

VaxCare has partnered with your healthcare provider to provide immunizations.

All bills for privately insured patients will come from VaxCare and its physicians.

Parent Consent for Independence City HD Vaccination Clinic

Partner ID: 116554 **Partner Name:** Independence Health Department

Clinic ID: **School Name:**

Patient ID:

INDEPENDENCE CITY HD

Consent ID:

① School and Student Information

STUDENT FIRST NAME | MI | STUDENT LAST NAME | AGE | GRADE | GENDER: ☐ M ☐ F

DATE OF BIRTH (MM▪DD▪YYYY) | SCHOOL NAME | HOME ROOM TEACHER

ETHNICITY: ☐ Amer. Indian / Alsk. Native ☐ Asian ☐ Black / Afr. Amer. ☐ Hawaiian / Pac. Islnd. ☐ Hispanic ☐ White ☐ Other_____

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

Please fill in the circle to the left of your primary insurance name.

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

PRIMARY INSURANCE NAME | MEMBER / INSURED ID# | GROUP ID

RELATIONSHIP TO THE SUBSCRIBER/INSURED: ☐ Self ☐ Spouse ☐ Dependent

SUBSCRIBER/INSURED FIRST NAME | SUBSCRIBER/INSURED LAST NAME | SUBSCRIBER/INSURED DOB (MM▪DD▪YYYY) | GENDER: ☐ M ☐ 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.

☐ MEDICAID STATE ID # | MEDICAID PLAN NAME

☐ 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 to 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. 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 been given and read, or have had explained to me the information from the current Vaccine Information Statement(s). I 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 | DATE

FOR OFFICE USE ONLY - BLACK INK ONLY

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

☐ VFC ☐ VAXCARE

☐ Prefilled Syringe 0.5 mL (36 mths & older)

LOT#

SITE: ☐ LD ☐ RD ☐ LL ☐ RL Other_____

DELIVERY: ☐ IM ☐ ID Other_____

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 if there is any reason we should not give your child inactivated injectable influenza vaccination. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. We will assess your questionnaire and provide vaccination to your child based on their health history and the supply of vaccine available.

	YES	NO
1. Is the person to be vaccinated sick today?	☐	☐
2. Does the person to be vaccinated have an allergy to latex, mercury, thimerosal, gelatin, chicken eggs/feathers, or other vaccine components? Please explain:_____	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? Please Explain:_____	☐	☐
4. Has the person to be vaccinated ever had seizures, Guillian-Barre syndrome, or any other neurological diseases? Please explain:_____	☐	☐
5. Does the person to be vaccinated have an allergy to medication, food, or other vaccines? Please explain:_____	☐	☐
6. Does the person to be vaccinated have any chronic medical conditions such as: heart disease diabetes, kidney disease, cancer, or immune system disorder? Please Explain:_____	☐	☐
7. In the past three months, has the person to be vaccinated taken any cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments? Please explain:_____	☐	☐
8. Has the person to be vaccinated received the Flu vaccine in the past? If yes, when did they receive it and what type was it? _____	☐	☐

VaxCare