VaxCare

Parent Consent for Independence City HD Vaccination Clinic

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

Partner ID: | **Partner Name:**
Clinic ID: | **School Name:**
Patient ID:

INDEPENDENCE CITY HD

Consent ID:

① Patient Information

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

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

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 (if patient is minor) | PARENT/GUARDIAN LAST NAME (if patient is minor) | 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
- ◯ Anthem/BCBS
- ◯ BCBS Federal
- ◯ BCBS Kansas City
- ◯ CIGNA
- ◯ Coventry
- ◯ Golden Rule
- ◯ Great West-CIGNA
- ◯ First Health
- ◯ HealthLink
- ◯ 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 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 me. I give Independence City Health Department permission to exchange my 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.

☐ SELF PAY | AMOUNT $

Checks only. Please make out checks to The City of Independence.

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 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.

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: ☐ Adacel/Boostrix ☐ Fluzone ☐ FluMist ☐ Pneumovax23

Product Name:	LOT#	SITE: ☐ LD ☐ RD ☐ LL ☐ RL Other_____	DELIVERY: ☐ IM ☐ SQ ☐ PO ☐ IN Other_____
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Product Name:	LOT#	SITE: ☐ LD ☐ RD ☐ LL ☐ RL Other_____	DELIVERY: ☐ IM ☐ SQ ☐ PO ☐ IN 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 staff of ISD: The following questions will help us determine which vaccines you may be given at school on your assigned day. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. We will assess your questionnaire and provide the best type of vaccine for you based on your health status and the supply of vaccine available. Please circle all answers that apply to you.

	YES	NO
1. Have you had an allergic reaction to latex, eggs, gelatin or Neomycin?	☐	☐
2. Have you had a serious reaction to a vaccine in the past?	☐	☐
3. Have you ever been told you have asthma? (Not able to receive Mist if Yes)?	☐	☐
4. Are you pregnant/nursing or is there a chance you could become pregnant during the next month?	☐	☐
5. Do you have any chronic medical conditions such as: smoker, heart disease, diabetes, kidney disease, cancer, any immune system problem, had your spleen removed, had a cochlear implant or an organ or bone marrow transplant?	☐	☐
6. Do you have a seizure or neurological disease or a history of Guillian-Barre syndrome?	☐	☐
7. Have you received the Flu, Pneumovax or Tdap vaccine in the past? If yes, when and what type:_____	☐	☐
8. Have you received any vaccination in the past 4 weeks?	☐	☐
9. Are you 65 or older and a) never received a Pneumococcal vaccine b) received 1 or 2 doses when you were under 65? C) if either, has it been at least 5 years since last vaccine?	☐	☐

10. Vaccine Preference:
- ☐ FluMist (Nasal Spray/Live Vaccine)
- ☐ Fluzone (Shot/Inactivated Vaccine)
- ☐ No preference
- ☐ Pneumococcal (PPSV23)
- ☐ Tdap

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