** Vaccine Consent Form**

TDAP O Meningococcal O

 **School Name:**

PLEASE COMPLETE ALL OF THE INFORMATION BELOW **- Please print using ink** **(**Incomplete forms will not be accepted)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FIRST NAME of Student:** |  |  |  |  |  |  |  |  |  |  |  |  | **LAST NAME of Student:** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Gender: Male Female** | **Birthdate: (mo,day,yr)** |  |  | / |  |  | / |  |  |  |  | **Age Homeroom Teacher / Grade** |
| **Address**  | **Home Phone # ( ) - Cell Phone # ( ) -** |
| **City Zip Code State** | **Student Race:** (Circle one) African American / Black White Alaskan/ Native American Asian Hawaiian / Pacific Islander Other **Ethnicity:** Non-Hispanic or Hispanic |
| **The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.****Please fill out the following questions pertaining to your child’s Health Insurance:** |
| Parent / Guardian Information |
| First Name | Last Name | Relationship to Patient |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |
| Required insurance information (must Check an appropiate box) |
| **medicaid & managed care organizations** |
| **Buckeye** | **care source** | **molina** | **paramount advantage** | **uhc community plan** | **straight medicaid** | **other: (Please specify Name)** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |
| **Member Id#** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **Case #** |  |  |  |  |  |  |  |
|  |
| **mmis# (patient’s medicaid #) Note: This is the only # required for buckeye patients** |  |  |  |  |  |  |  |  |  |  |  |  |  | **Currently have no Insurance \*Note: it is fraudulent to claim uninsured if you have insurance** |  |
|  |
| **Private Insurance Companies** |
| **Aetna** | **BCBS** | **CIgna** | **core source** | **humana** | **medical mutual** | **tri-care** | **uhc** | **other: (please specify name)** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |
| **Cardholder’s first name** | **Cardholder’s last name** | **cardholder’s date of birth** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | M | M | **/** | D | D | **/** | Y | Y | Y | Y |
| **Identification# / Member id# / Enrollee ID # (include alpha prefix, if shown on card)** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **payer id# (if noted on card)** |  |  |  |  |  |  |  |  |
|  |
| **VACCINATION & HEALTH-RELATED QUESTIONS** |
| 1 | Has your child ever had a life threatening reaction(s) to the any vaccine in the past? | **YES** | **NO** |
| 2 | Has your child ever had Guillain-Barre’ syndrome? | **YES** | **NO** |
| 3 | Does your child have an allergy to eggs? | **YES** | **NO** |
| 4 | Does your child have a blood disorder such as hemophilia? | **YES** | **NO** |
| 5 | Will this be the first time your child has ever received a flu vaccination? | **YES** | **NO** |
| **IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD’S PEDIATRICIAN OR CALL US AT 334-738-4840 TO SPEAK TO A REPRESENTATIVE.** |
|  I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at [www.immunize.org](http://www.immunize.org) or [www.cdc.gov](http://www.cdc.gov). I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine’s success. I hereby release the school system, HNH Immunizations, Inc. & subsidiaries, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. Clinic dates can be obtained from the school. I understand that the health related information on this form will be used for insurance billing purposes and your privacy will be protected. **Health Heroes of Ohio, Inc** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 326 Prairie St. North Signature of Parent/Guardian Printed Name of Parent/Guardian Date Union Springs, AL 36089 **AL@healthherousa.com** **334-738-4840**  |
| IS CDC 02/24/2015 ADACEL TDAP VACCINE 0.5MLLOT Number: EXP Date:RN #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AREA FOR OFFICIAL ADMINISTRATION USE ONLY | VIS CDC 03/31/2016 MENACTRA MENINGOCOCCAL ACYW 0.5MLLOT Number: EXP. Date:RN#\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AREA FOR OFFICIAL ADMINISTRATION USE ONLY |