HEALTH HERO
You Keep Them Smart
We Keep Them Healthy

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 or 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.

Signature of Parent/Guardian _____ Printed Name of Parent/Guardian _____ Date _____

Health Heroes of Ohio, Inc
326 Prairie St. North
Union Springs, AL 36089
AL@healthherousa.com
334-738-4840

IS CDC 02/24/2015 ADACEL TDAP VACCINE 0.5ML
LOT Number: EXP Date:
RN #_____ Date:_____
AREA FOR OFFICIAL ADMINISTRATION USE ONLY

VIS CDC 03/31/2016 MENACTRA MENINGOCOCCAL ACYW 0.5ML
LOT Number: EXP. Date:
RN#_____ DATE:_____
AREA FOR OFFICIAL ADMINISTRATION USE ONLY