VaxCare

Parent Consent For Whitley County Health Department 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: 115713

Partner Name: Whitley County Health Department

Clinic ID: 1882598

School Name:

Patient ID:

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 Sec Hor	◯ Care Improv Plus	◯ GWH-Cigna	◯ Medicare B	◯ Patoka V-Key Ben	◯ Patoka V-SIHO	◯ Three Rivers
◯ Adv Health Sol	◯ CIGNA	◯ Healthspan	◯ Medicare RR	◯ Patoka V-Medben	◯ Patoka V-UMR(Fiserv)	◯ UHC
◯ Adv-Franc Alli	◯ Coventry	◯ Humana	◯ Multiplan	◯ Patoka V-Meritain	◯ Patoka V-Unif Gr Sv	◯ UMWA
◯ Aetna	◯ Dunn & Assoc	◯ IU Health Plans	◯ Patoka V-Allied Ben	◯ Patoka V-Merit (CBSA)	◯ Patoka V-WebTPA	◯ UMR
◯ All Savers	◯ Encore Hlth Net	◯ Lutheran Pref	◯ Patoka V-Dunn & As	◯ Patoka V-N Am Admin	◯ Professional Benefit Admin	
◯ Anthem/BCBS	◯ First Health	◯ Mail Handlers	◯ Patoka V-Emp Plans	◯ Patoka V-Pekin Insur	◯ Sagamore	
◯ BCBS Federal	◯ Golden Rule	◯ Mngd Hlth Sv (age 19+)	◯ Patoka V-Healthsmrt	◯ Patoka V-ProClaim+	◯ SIHO	

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 #

☐ 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 Whitley County Health Department for any services provided to my child. I give Whitley County 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 Whitley County 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 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: ☐ TDap ☐ Hep A ☐ Menveo ☐ Bexsero ☐ HPV

Product Name:	LOT#	SITE: ☐ LD ☐ RD ☐ LL ☐ RL Other___ DELIVERY: ☐ IM ☐ SQ ☐ PO ☐ IN Other___	Product Name:	LOT#	SITE: ☐ LD ☐ RD ☐ LL ☐ RL Other___ DELIVERY: ☐ IM ☐ SQ ☐ PO ☐ IN Other___
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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).

(888) 829-8550 www.vaxcare.com

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____/____/____
month day year

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	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medicine, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?	☐	☐	☐
5. For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. For babies: Have you ever been told the child had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?	☐	☐	☐
8. Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
9. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?	☐	☐	☐
10. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
11. Does the child's parent or sibling have an immune system problem?	☐	☐	☐
12. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐
13. Is the child/teen pregnant?	☐	☐	☐
14. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐
15. Has the child ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
16. Is the child anxious about getting a shot today?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

Immunize.org

FOR PROFESSIONALS www.immunize.org / **FOR THE PUBLIC** www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf
Item #P4060 (12/10/2024)

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