Parent Consent for Seasonal Influenza Vaccination

dhec Healthy People. Healthy Communities.

VaxCare

FOR CLINIC USE ONLY ☐ VFC ☐ VAX ☐ STATE 2nd Dose Needed?: ☐ YES ☐ NO

Partner ID: **Partner Name:**

Clinic ID: **School Name:**

VaxCare has partnered with your healthcare provider to provide immunizations.

All bills for privately insured patients will come from either VaxCare or DHEC.

Consent ID:

School and Student Information (use black ink only)

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 HOME PHONE:

PARENT/GUARDIAN EMAIL: | PARENT/GUARDIAN CELL PHONE:

Insurance Information (Please fill out completely!)

☐ INSURANCE PAY ☐ Aetna ☐ BCBS ☐ CIGNA ☐ Golden Rule ☐ Mail Handlers ☐ Med Mutual ☐ Tricare ☐ United Healthcare ☐ Blue Choice ☐ Carolina Care ☐ Coventry ☐ Humana ☐ Medcost ☐ PAI ☐ UMR ☐ Wellpath

PRIMARY INSURANCE | 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 influenza vaccine if my insurance company does not pay. I acknowledge that I have been provided access to the VaxCare Privacy Notice for my review.

☐ 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 the South Carolina Department of Health and Environmental Control (DHEC) for any services provided to my child. I give DHEC 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 DHEC for services rendered. I acknowledge that I have been provided access to the DHEC Privacy Notice for my review.

Authorization and Consent

Consent for Use of Protected Health Information & Claims Assignment: I hereby 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 payment from the insurer listed above to VaxCare or DHEC associated with the services contemplated herein. Vaccine Authorization: I consent for my child to receive the seasonal influenza vaccine at school. I have read the Vaccine Information Statement. I have had an opportunity to ask questions about the vaccine. I understand the risks and benefits of the vaccine. I understand that the vaccine will be given as a shot. I have read and answered the questions on the back of this form carefully and accurately, and I understand that incorrect information could cause serious risks to my child. I consent to my child receiving a second dose of the seasonal influenza vaccine at a school clinic if my child is less than 9 years old and a second dose is recommended by the U.S. Centers for Disease Control and Prevention (CDC). In case of occupational exposure, I consent to my child's blood testing if necessary for child and employee safety. I understand that immunization information about my child will be reported to the SC Immunization Registry for public health purposes. **I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action against VaxCare 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. The foregoing arbitration provisions do not affect or apply to any disputes with or claims by or against DHEC or any action to which DHEC is a party, regardless of whether VaxCare is also a party. DHEC does not consent to arbitration to resolve any claims, disputes, or actions.** If consenting for another: I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

SIGNATURE of PARENT or LEGAL GUARDIAN | DATE

**** PLEASE TURN THE PAGE OVER AND COMPLETE SCREENING QUESTIONS ON BACK BEFORE RETURNING TO SCHOOL →****

Vaccination Details (Influenza: VO4.81) FOR CLINIC USE - BLACK INK ONLY

FIRST DOSE ☐ VFC ☐ VAXCARE ☐ STATE

MFR / LOT ☐ SP ☐ GSK

☐ IIV4

☐ LD ☐ RD ☐ Other_____

☐ "What to Know After..." given to student

☐ Unable to vaccinate student due to_____ "Unable to Vaccinate" form given to student

VIS DATE 8/7/2015

NURSE SIGNATURE | DATE (MM▪DD▪YYYY)

Nurse: I hereby attest by signature above that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consent for vaccination.

PATIENT/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE

Teacher: I hereby attest by signature above that the identity of the patient in question has been verified.

SECOND DOSE ☐ VFC ☐ VAXCARE ☐ STATE

MFR / LOT ☐ SP ☐ GSK

☐ IIV4

☐ LD ☐ RD ☐ Other_____

☐ "What to Know After..." given to student

☐ Unable to vaccinate student due to_____ "Unable to Vaccinate" form given to student

VIS DATE 8/7/2015

NURSE SIGNATURE | DATE (MM▪DD▪YYYY)

Nurse: I hereby attest by signature above that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consent for vaccination.

PATIENT/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE

Teacher: I hereby attest by signature above that the identity of the patient in question has been verified.

Influenza Vaccination: The following questions will help us determine if there is any reason we should not give your child a seasonal influenza vaccination. If a question is not clear, please ask your healthcare provider to explain it. PLEASE ANSWER ALL QUESTIONS.

1. Has your child ever had a serious reaction to eggs OR a serious reaction to a previous flu vaccine that caused any of the following: wheezing, trouble breathing, hives and itching all over the body, swelling in the mouth or throat, very low blood pressure or shock? **NO** ☐ **YES** ☐

2. Has your child ever had Guillain-Barre Syndrome (a rare type of temporary severe muscle weakness and paralysis)? **NO** ☐ **YES** ☐

If you answered YES to any of the questions above, your child cannot receive the 2016-2017 seasonal influenza vaccine at school. Please contact your primary healthcare provider about the flu vaccine.

If you answered NO to the above questions, please complete the following additional questions:

3. **If your child is under 9 years old**, he/she may need 2 doses of flu vaccine. Please provide your child's date of birth ONLY if your child is under 9 years old. **DOB:**____/____/_____

4. **If your child is under 9 years old,** has your child received at least two doses of influenza vaccine prior to July 1, 2016? **NO** ☐ **YES** ☐ **UNSURE** ☐

Notes:

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