VaxCare

Consent for Chester County HD Vaccination Clinic

CHESTER HD

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: 116828 Partner Name: Chester County Health Department

Clinic ID: School Name:

Patient ID:

Consent ID:

① Patient Information

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

DATE OF BIRTH (MM▪DD▪YYYY)

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 | **PHONE NUMBER**

② Contraindication Questions

The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or 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
1. Is the person to be vaccinated sick today?	☐	☐
2. Does the person to be vaccinated have an allergy to mercury, thimerosal, or chicken eggs?	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to an influenza vaccine in the past?	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré Syndrome?	☐	☐

③ Insurance Information (please fill out completely!)

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 or 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 or myself

④ 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 insurance provided to VaxCare associated with the services contemplated herein if client is insured. Vaccine Authorization: My signature on this form indicates that I have requested that a flu vaccine be administered to me by Chester County Health Department. 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 and understand the risks (including adverse reactions) and benefits of the vaccine. I understand I will be responsible for payment for the flu vaccine, if insured. Additionally, I understand that if I am a self-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.)

☐ Sanofi Pasteur

☐ GSK

LOT#

EXP. DATE: _____

SITE: ☐ LD ☐ RD ☐ LL ☐ RL

DELIVERY: ☐ IM

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).

