LCHD Vaccine Consent Form

VAXCare/VFC

Clinic Info

Partner / Clinic Name: **Lake County Health Department**

Date of Service

Payment & Patient Info

Patient Name | Date of Birth | Gender | Phone

Address | Social Security #

Payer Name | Member ID | Group ID

Insured Name | Insured Date of Birth | Ins. Gender | Relation to Insured

SIIS #

Email

Check Out Doses

Check out and scan all ordered doses on the VaxCare Hub by the end of day.

Vaccine	Lot #	Site	Route
		☐☐☐☐ LD LL RD RL	☐☐☐☐ IM SQ IN PO
		☐☐☐☐ LD LL RD RL	☐☐☐☐ IM SQ IN PO
		☐☐☐☐ LD LL RD RL	☐☐☐☐ IM SQ IN PO
		☐☐☐☐ LD LL RD RL	☐☐☐☐ IM SQ IN PO
		☐☐☐☐ LD LL RD RL	☐☐☐☐ IM SQ IN PO
		☐☐☐☐ LD LL RD RL	☐☐☐☐ IM SQ IN PO

Administrator Name | Administrator Signature | Administration Date

Collect 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.

Patient Signature | Date

School Immunization Clinic Parental Consent Form

School Name _____ Clinic Date _____

In order for your child to obtain the adolescent vaccinations during this school based clinic, you must
1. **Complete** both sides of this form, 2. **Provide** previous vaccination records, and 3. **Sign & Date** this form.

A. INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT)

Student's Name Last _____ First _____ Middle _____

Student's Birth Date _____ Age _____ Gender ☐ *Male* ☐ *Female*

Parent/Guardian Name Last _____ First _____ Relationship _____

Student's Address _____ City _____ Zip Code _____

B. VACCINE ELIGIBILITY SCREENING (PLEASE CHECK APPROPRIATE BOX)

☐ **Medicaid** A child, 0 through 18 years of age, who has Medicaid as primary insurance.

☐ **American Indian/Alaskan Native** A child, 0 through 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance.

☐ **No Health Insurance** A child, 0 through 18 years of age, who does not have health insurance.

☐ **Insurance Does Not Cover Vaccines (Underinsured)** A child, 0 through 18 years of age, who has commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (these children are categorized as underinsured for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured).

☐ **Fully Insured** A child, 0 through 18 years of age, who has health insurance which provides coverage for vaccines. If primary insurance denies the claim and Medicaid is a secondary insurance, the healthcare provider will make the adjustment and bill Medicaid.

C. VACCINE HEALTH SCREENING (CIRCLE YES OR NO)

Please answer all questions about the student who will be receiving the vaccine(s). Answers will determine whether the student can be vaccinated at this time.

Yes ☐ No ☐ 1. Does the student have any allergies to medication, foods, or any vaccines?
If yes, please explain _____

Yes ☐ No ☐ 2. Has the student had a serious reaction to a vaccine in the past?

Yes ☐ No ☐ 3. Has the student had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?

Yes ☐ No ☐ 4. Has the student had a seizure, brain or other nervous system problem, including Guillain-Barré Syndrome?

Yes ☐ No ☐ 5. Does the student have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?

Yes ☐ No ☐ 6. Has the student taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?

Yes ☐ No ☐ 7. Has the student received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?

Yes ☐ No ☐ 8. Is the student pregnant or is there a chance she could become pregnant during the next month? *If yes, student should not receive MMR, HPV, or varicella vaccines.*

Yes ☐ No ☐ 9. Has the student received vaccinations in the past four (4) weeks?
If yes, please list vaccines _____

Form Reviewed by _____ **Date** _____

School Immunization Clinic Parental Consent Form

I give permission to the Lake County Health Department, the Indiana State Department of Health, and/or their designee to vaccinate the student named on this form.

Signature of Parent/Guardian _____ Date _____

PROOF OF VACCINATION

School _____

We recently provided immunization services to your patient. We want to make certain that you have information about the vaccines or antibody product we administered so you can update your patient's medical record. Please contact us if you have any questions about this information.

☐ We provided the patient (or parent/guardian) with a written record of the immunization(s) given.

☐ We entered information about the immunization(s) we administered in the regional or state immunization information system.

Student's Name _____ Student's Birthdate _____ (MM/DD/YR)

The immunizations we administered on _____ (DATE) is/are checked below.

IMMUNIZATIONS ADMINISTERED

COVID-19
- ☐ mRNA (circle one): Moderna Pfizer
- ☐ Novavax

Hepatitis B
- ☐ Engerix-B; Recombivax HB; DOSE (circle one): 0.5 mL 1.0 mL
- ☐ Heplisav-B (age 18 yrs and older)

☐ **DTaP** (age 6 yrs and younger)
☐ **DTaP-HepB-IPV** (Pediarix)
☐ **DTaP-IPV** (Kinrix, Quadracel)
☐ **DTaP-IPV/Hib** (Pentacel)
☐ **DTaP-IPV-Hib-HepB** (Vaxelis)
☐ **Tdap** (age 7 yrs and older)
☐ **Td** (age 7 yrs and older)

Hib (monovalent)
- ☐ ActHIB (PRP-T)
- ☐ Hiberix (PRP-T)
- ☐ PedvaxHIB (PRP-OMP)

☐ **Influenza**
BRAND _____
DOSE (mL) _____
ROUTE (circle one): IM Nasal

☐ **IPV** (Polio)

Pneumococcal conjugate (PCV)
- ☐ PCV13, Prevnar 13
- ☐ PCV15, Vaxneuvance
- ☐ PCV20, Prevnar 20
- ☐ PCV21, Capvaxive

☐ **Pneumococcal polysaccharide** (PPSV23) (Pneumovax 23)

Respiratory Syncytial Virus (RSV)
- ☐ Abrysvo (Pfizer)
- ☐ Arexvy (GSK)
- ☐ mResvia (Moderna)

RSV Monoclonal Antibody
- ☐ Nirsevimab (Beyfortus)

Rotavirus
- ☐ RV1 (Rotarix) ☐ RV5 (RotaTeq)

☐ **Human papillomavirus** (9vHPV) (Gardasil 9)
☐ **MMR** (MMR II, Priorix)
☐ **Varicella** (chickenpox) (Varivax)
☐ **MMRV** (ProQuad)
☐ **Hepatitis A** (Havrix; Vaqta) DOSE (circle one): 0.5 mL 1.0 mL
☐ **HepA-HepB** (Twinrix) (age 18yrs+)
☐ **Meningococcal ACWY** (MenACWY)
- ☐ MenQuadfi ☐ Menveo

☐ **Meningococcal ABCWY** (Penbraya)

Meningococcal B (MenB)
- ☐ Bexsero (MenB-4C)
- ☐ Trumenba (MenB-FHbp)

☐ **Mpox** (Jynneos)
☐ **Zoster** (shingles) (RZV) (Shingrix)
☐ **Other** _____

Lake County Health Department
NAME OF CLINIC PROVIDING SERVICES

CLINIC CONTACT PERSON

2900 W. 93rd Ave
ADDRESS

EMAIL ADDRESS

Crown Point, IN 46307
CITY/STATE/ZIP

(219) 755-3655
PHONE