

Vaccine Consent Form

Please select the vaccine(s) you consent for your child to receive:

Tdap ☐

MCV ☐

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				Mother's Maiden Name (For Registry)												
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 APPROPRIATE 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

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) after a previous dose of any diphtheria, tetanus or pertussis containing vaccine?	YES	NO
2	Has your child ever had a life-threatening allergic reaction after a previous dose of meningococcal ACWY vaccine?	YES	NO
3	Has your child ever had a condition called Guillain Barré Syndrome (GBS)?	YES	NO
4	Does your child have a blood disorder such as hemophilia?	YES	NO
5	Has your child ever had seizures or another nervous system problem?	YES	NO



IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL US AT 205-609-0268 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, Health Heroes of Ohio, Inc., HNH Immunizations, Inc., MaxVax LLC., & 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. I acknowledge that I am giving permission for Health Heroes, Inc. to adjudicate and appeal claims with my insurance providers on my behalf. 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. I request and voluntarily consent for the vaccine to be given and recorded in the state registry for the person listed above.

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
205-609-0268



IS CDC 04/01/2020
LOT Number:
RN #
AREA FOR OFFICIAL ADMINISTRATION USE ONLY

TDAP VACCINE 0.5ML
EXP Date:
Date:

VIS CDC 08/15/2019
LOT Number:
RN# DATE:
AREA FOR OFFICIAL ADMINISTRATION USE ONLY

MENINGOCOCCAL ACYW 0.5ML
EXP. Date: