

Parent Consent for Tdap Vaccination



FOR CLINIC USE ONLY

VFC VAX State

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:

Partner ID:
 Clinic ID:

Partner Name:
 School Name:

School and Student Information - COMPLETE IN BLACK INK ONLY. PLEASE PRINT.

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 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 Tdap 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 Tdap 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 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. 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 (Tdap: VO6.8) FOR CLINIC USE - BLACK INK ONLY

MFR / LOT SP GSK

VIS DATE 2/24/15

NURSE SIGNATURE DATE (MM=DD=YYYY)

VFC VAXCARE STATE "What to Know After..." given to student

LD RD Other _____ Unable to vaccinate student due to "Unable to Vaccinate" form given to student

PATIENT/STUDENT'S ASSIGNED CLASSRM TEACHER SIGNATURE

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

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

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

1. Has your child previously received a dose of Tdap vaccine (anytime on or after his/her 7th birthday)? YES NO

If you answered YES to question #1, then STOP and provide a South Carolina Certificate of Immunization to your child's school showing that he/she has received the Tdap vaccine required for entry into seventh grade.

If you answered NO to Question #1 above, please complete Questions #2 - #7 if you want your child to receive Tdap vaccine.

2. Has your child ever had a serious allergic reaction after a dose of any tetanus, diphtheria, or pertussis containing vaccine (DTP, DTaP, DT, Td, or Tdap) 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? YES NO
-
3. Has your child ever had a serious allergic reaction to latex 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? YES NO
-
4. Has your child ever been in a coma or had long or multiple seizures within 7 days of getting a dose of DTP or DTaP vaccine? YES NO
-
5. Has your child had severe swelling or severe pain after a previous dose of any of the following vaccines: DTP, DTaP, DT, Td, or Tdap? YES NO
-
6. Has your child ever had Guillain Barre Syndrome (GBS) (a rare type of temporary severe muscle weakness and paralysis)? YES NO
-
7. Does your child have epilepsy or another nervous system problem? YES NO

If you answered YES to any of the questions above, your child cannot receive the Tdap vaccine at the school's vaccination clinic. Please contact your primary healthcare provider about the Tdap vaccine.

Notes:



FOR CLINIC USE ONLY

VFC VAX State