HEALTH HERO

VACCINE CONSENT FORM

Scan QR code for Vaccine Information Statement

School Name: _____

PLEASE COMPLETE ALL OF THE INFORMATION BELOW – Please print using ink (Incomplete forms will not be accepted)

FIRST NAME OF STUDENT		MIDDLE INITIAL		LAST NAME OF STUDENT				SUFFIX	
GENDER: Male (M) Female (F)		Birth date (mo/day/yr)		AGE		GRADE		HOMEROOM TEACHER	
ADDRESS								MOTHER'S MAIDEN NAME	
CITY		STATE		ZIP CODE		PHONE			
EMAIL									

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.

MY CHILD IS ENROLLED WITH MEDICAID (VFC ELIGIBLE) (mark with an X)		MY CHILD HAS COMMERCIAL INSURANCE (NOT VFC ELIGIBLE) (mark with an X)			
Alabama Medicaid		BCBS / All kids		MEMBER ID POLICY NUMBER	
		Aetna		INSURANCE COMPANY NAME	
		CHAMPVA		POLICY HOLDER's FIRST NAME	
		Cigna		POLICY HOLDER's LAST NAME	
		Tricare		BIRTH DATE (mo/day/yr)	
		UMR- Wausau			
		United Health Care			
		Viva Health Plan		MY CHILD HAS NO INSURANCE (VFC ELIGIBLE) (mark with an X)	

STOP

Do NOT return this form unless you want your child to be vaccinated.

STUDENT RACE (mark with an X)		ETHINICITY (mark with an X)	
African American/Black		Hispanic	
White		Non-Hispanic	
Asian			
Hawaiian / Pacific Islander			
Alaskan / Native- American			
Other			

HEALTH QUESTIONS (mark with an X)	YES	NO
Will this be the first time your child has received a flu vaccine?		
Has your child ever had an adverse reaction to any vaccine in the past including Guillain Barre syndrome?		
Does your child have a blood disorder such as hemophilia or sickle cell?		

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, HNH Immunizations Inc., MaxVax LLC., Health Heroes and it's affiliates, 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 HNH Immunizations 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 approve the use of my phone number to receive health related information. I request and voluntarily consent for the vaccine to be given and recorded in state registry for the person listed above.

PARENT/GUARDIAN WITH AUTHORITY TO AUTHORIZE VACCINATIONS SIGNATURE					
NAME		LASTNAME		DATE OF SIGNATURE (mo/day/yr)	
SIGNERS DATE OF BIRTH (mo/day/yr)				RELATIONSHIP TO CHILD	

Area for Official Administration Use Only
VIS CDC IIV 08/06/2021
Lot # _____ Exp: _____
Date: _____
_____ LPN/RN/MD

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD's PEDIATRICIAN OR CALL US AT 205-609-0268 TO SPEAK TO A REPRESENTATIVE, PLEASE SEE WWW.HEALTHHEROUSA.COM FOR MORE INFORMATION

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205-609-0268