Full School Name:

Student Vaccine Consent Form

Grade:

Teacher:

First Name: Middle Initial:

Last Name: Gender:

Address: Apt #:

City: State: Zip:

Phone: - - (home, cell, work) Birthdate: M M D D Y Y Y Y Age:

Race: E-Mail:

Ethnicity (please select one:) ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ American Indian/Alaskan Native

☐ PATIENT DOES HAVE HEALTH INSURANCE (please fill out information below) ☐ PATIENT DOES NOT HAVE HEALTH INSURANCE

PRIMARY Insurance Company: Member/Subscriber ID:

Group# Claim Submission Address (see back of card):

Primary Insured Name: Relationship to Patient:

Birthdate: Social Security Number:

Address of Primary Insured (if different from patient)

SECONDARY Insurance Company: Member/Subscriber ID:

Group# Claim Submission Address:

Secondary Insured Name: Relationship to Patient:

Birthdate: Social Security Number:

Address of Secondary Insured (if different from patient)

Please answer the following questions:	
1. Are you sick today?	Yes ☐ No ☐
2. Are you allergic to eggs? (Can't eat eggs)	Yes ☐ No ☐
3. Have you ever had a serious reaction after receiving a vaccination? (difficulty breathing, swelling of the tongue, lips or throat)	Yes ☐ No ☐
4. Have you ever had a paralyzing illness (Guillain Barre Syndrome) after a flu vaccination?	Yes ☐ No ☐
5. If under age 9 years, has your child received 2 or more flu vaccines in their life time?	Yes ☐ No ☐

Vitae Care (VC) may keep this record in your medical file. VC will record what vaccine was given, the date the vaccine was given, the name of the company that made the vaccine, the vaccine lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking recall and recording, unless I request otherwise. I have read or have had explained to me the information sheet about influenza disease and the influenza vaccine. I have had a chance to ask questions, and they were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request. My medical information will not be shared without an authorization to release information. A copy of the Health Districts Notice of Privacy Practices (HIPAA) will be provided and is also located on www.colorado.gov/pacific/hcpf/notice-privacy-practices website. I authorize my insurance company to assign the amount payable directly to VC. I understand that I am financially responsible for all the charges that are not covered under my private insurance plan. I acknowledge that any co-payment is due and payable on the date services are received.

ONLY THE FLU SHOT IS AVAILABLE

Parent/Guardian Name (please print clearly): Parent/Guardian DOB:

Parent/Guardian Signature: (please sign after printing consent)

Relationship to Patient: Date:

Nurses: _____NN _____IMPACT Admins: _____Ins. Check _____NN _____IMPACT