MARGARET MARY HEALTH

Student – Consent for Flu Vaccine

Child's Legal Last Name:		Child's Legal First name:	Sex: M F		Child's Date of Birth: / /
Grade:	School:	Doctor:	Home/Cell Phone:		
Address:		City:		St:	Zip:

1.	Has your child ever had a severe, life-threatening allergic reaction to a previous flu vaccine? Allergic reaction: hives, rash that covers body, difficulty breathing, etc.	❐ This is the first time he/she has ever received a flu vaccine	**Yes No**
2.	Does your child have a severe, life-threatening allergy to eggs?		**Yes No**
3.	Has your child ever had Guillain-Barre syndrome? (A rare nerve disorder that can cause paralysis)		**Yes No**

4. Please mark one and write in the information requested.

- ☐ **Medicaid**. Policy #: __________________________ A child, 0 through 18 years of age, who has any form of Medicaid, MD-Wise, Hoosier Healthwise, Anthem Medicaid, or MHS (Managed Health Services). The vaccine will be provided for free.
- ☐ **No Health Insurance.** A child, 0 through 18 years of age, who does not have health insurance. The vaccine wil be provided for free.
- ☐ **Insurance Does Not Cover Vaccines.** A child, 0 through 18 years of age, who does have insurance, but the insurance does not cover vaccine(s). The vaccine will be provided for free.
- ☐ **Insurance Covers Vaccines.** Charges will be submitted to insurance company. Please complete below.

Subscriber's Legal Name:
(person who actually has the insurance) ____

Subscriber's
Date of Birth: __________________________

Insurance Name: __________________________ Policy #:________________ Group #:________________________

Subscriber's address: ______________________ City:___________________ St:__________ Zip:____________

Consent to Vaccinate: I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for each vaccine my child will be receiving. I have had a chance to ask questions and fully understand the benefits and risks of each vaccine. **Consent to Treat:** I hereby request and authorize MMH-employed physicians and their staff to administer immunization(s) to my child. I authorize staff to perform various serum tests on a sample of my child's blood in the event that a health care worker has accidently been exposed to his/her blood or bodily fluids. **Release of Information:** I authorize MMH staff to release information that may be requested or required by the third party payer (insurance company, government agency or its respective agents, or employer), to the extent necessary to secure payment. **Assignment of Benefits:** I hereby authorize payment directly to MMH in return for rendering the services described herein. **Privacy Practices:** I understand that the MMH Joint Notice of Privacy Practices provides information about how MMH may use and disclose protected health information. By signing this form I acknowledge that I have either: (a) received and reviewed a copy of the Notice via hard copy or email; or (b) have been offered an opportunity to receive the Notice but do not wish to do so. A copy of the Notice can be requested at any time by contacting (812) 933-5291. **Financial Responsibility:** I acknowledge and agree that: (i) I am legally responsible for this account and all costs associated with the collection of this account; (ii) account balances after insurance must be paid in full within thirty (30) days of patient billing, unless other payment arrangements have been made, to avoid collection placement; (iii) any costs or expenses we incur to collect payment from you, including collection fees, attorney fees or other fees will be added to any outstanding balance; and (iv) there will be a $25.00 service charge on all returned checks. **Release:** I knowingly and voluntarily assume all risk in connection with my child's receipt of an immunization. I hereby release MMH, its directors, officers, physicians, employees and agents from any and all liability or claim for damages arising from or related to such immunization. I further acknowledge that no guarantees have been made to me as to the results of an immunization and that it is solely my responsibility to follow up with a physician for any medical diagnosis, examinations, advice or treatment.

5. ____ __________________ ______________________________

Signature of Parent/Legal Representative **Date** **Relationship to Child**

Office Use Only:

Funding Source: Insurance
Manufacturer: GSK
Lot #: C54L3
Exp date: 6-30-17
VIS dated: 8-7-15

Date administered:

Administered IM by:

Deltoid: Left Right