VACCINE CONSENT FORM

School Name:	Clinic Date: April 30, 2024

PLEASE INITIAL THE VACCINE(S) YOU CONSENT FOR YOUR CHILD TO RECEIVE- SCAN FOR INFORMATION REGARDING EACH VACCINE

TDAP Ages 11 & 12 Tetanus, diphtheria & pertussis	MCV Ages 11&12 Meningococcal ACWY	MCVB Age 16+ Meningococcal B	HPV Age 11+ Human Papillomavirus (Cancer preventative)
PARENTS INITIALS	PARENTS INITIALS	PARENTS INITIALS	PARENTS INITIALS

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:**
GENDER: Male (M) Female (F)	Birth date: (mo/day/yr) M M D D Y Y Y Y	**AGE**	**GRADE** / **HOMEROOM TEACHER**
ADDRESS		**PHONE**	**MOTHER'S MAIDEN NAME**
CITY State Zip Code		**STUDENT RACE** (1)African American / Black (2) White; (3) Asian (4) Hawaiian / Pacific Islander (5) Alaskan/ Native-American (6) Other	**ETHNICITY** (1) Hispanic (2) Non-Hispanic
EMAIL ADDRESS:			

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 insured (YES/NO)	My child has Commercial Insurance:
My child is enrolled with Medicaid VFC Eligible (YES/NO)	Insurance Company Name:
POLICY	**POLICY HOLDER'S LAST NAME:**
MEMBER ID:	**DATE OF BIRTH:** M M D D Y Y Y Y

YES	NO	WRITE YES OR NO FOR EACH QUESTION
		1. Has your child ever had a life-threatening reaction(s) to the vaccines in the past?
		2. Does your child have an allergy to eggs?
		3. Does your child have a blood disorder such as hemophilia?
		4. Will this be the first time your child has ever received the selected vaccine(s)?

F 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 HTTP://WWW.HEALTHHEROUSA.COM FOR MORE INFORMATION.

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

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.

Printed Name of Parent/Guardian with Authority to Authorize Vaccinations	Signature of Parent/Guardian with Authority to Authorize Vaccinations	Relationship to Child	Date

HEALTH HERO You Keep Them Smart We Keep Them Healthy

HNH Immunizations, Inc. 326 Prairie Street North, Union Springs, AL 36089