Childhood Immunization Clinic Consent Form

Clinic name:_____ **Clinic Date:** _____

In order for your child to obtain the vaccinations during this clinic, you must:

☐**1. Complete** this form ☐**3. Provide** copy of Insurance/Medicaid card ☐ **5. Attach** check if uninsured

☐**2. Sign & Date** this form ☐ **4. Provide** copy of all prior vaccination records or send cash

ATTACH A COPY OF MEDICAID OR INSURANCE IDENTIFICATION CARD. INSURANCE/MEDICAID WILL BE BILLED FOR VACCINE ADMINISTRATION FEES. UNINSURED CHILDREN PAY $14/1 SHOT, $28/2 SHOTS, $42/3 SHOTS, $56/4+SHOTS. (NO CHILD WILL BE DENIED VACCINATIONS DUE TO INABILITY TO PAY.)

A. Information about person receiving vaccine (Please print)

Child's Name Last_____ First_____ Middle_____

Child's Birth Date_____ Age _____ Gender Male Female Phone #_____

Parent/Guardian Name Last_____ First_____ Relationship_____

Child's Address_____ City_____ Zip Code_____

Insurance Company: _____**Insurance Phone Number:** _____

Insurance Company address:_____

Policy/ID Number: _____**Group Number:** _____

Policy Holder Name: _____**Policy Holder DOB:** _____

Policy Holder Employer:_____

B. Vaccine Eligibility Screening (Please check appropriate box)

- ☐ **Medicaid:** A child, 0 thru 18 years of age, who has Medicaid coverage
- ☐ **American Indian/Alaskan Native:** A child, 0 thru 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance coverage
- ☐ **No Health Insurance:** A child, 0 thru 18 years of age, who does not have health insurance
- ☐ **Limited Health Insurance:** A child, 0 thru 18 years of age, who has health insurance, but the health insurance does not pay for vaccinations
- ☐ **Insured:** A child, 0 thru 18 years of age, who has health insurance which provides coverage for vaccines

C. Vaccine Health Screening (circle Yes or No)

Please answer all questions about the child who will be receiving the vaccine(s). Answers will determine whether the child can be vaccinated at this time. **If you respond 'Yes' to any of the questions, please explain in the space provided below.**

Yes	No	1. Does the child have any allergies to medication, foods, or any vaccines?
Yes	No	2. Has the child had a serious reaction to a vaccine in the past?
Yes	No	3. Has the child had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?
Yes	No	4. Has the child had a seizure, brain, or other nervous system problem, including Guillain-Barré Syndrome?
Yes	No	5. Does the child have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?
Yes	No	6. Has the child taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?
Yes	No	7. Has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?
Yes	No	8. Is the child pregnant or is there a chance she could become pregnant during the next month?
Yes	No	9. Has the child received vaccinations in the past four (4) weeks?

Please explain any 'Yes' responses._____

D. Eastern Idaho Public Health Insurance (EIPH) Liability Waiver:

The cost of a billable service is the responsibility of the client/guarantor. Regular monthly payments in any amount are accepted to keep accounts from going to a collection agency. For unpaid balances a payment plan can be arranged with the clerical staff. By signing, I consent to third party billing, including payment of government benefits to EIPH, and understand that services eligible for a sliding fee will be billed at 100% to third party payers.

Insurance (if applicable): As a courtesy, EIPH will bill your insurance for most immunization services; however, ***EIPH is not a preferred provider for all insurances***. It is recommended that you check with your health insurance regarding coverage. Client/guarantor will be billed for any remaining balances after insurance has been processed.

*****IMPORTANT******
COMPLETE BOTH SIDES

Child's Name:_____Patient's age:_____

E. 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 the all age appropriate vaccines indicated that could be given. I have had a chance to ask questions and fully understand the benefits and risks of each of the indicated vaccine and consent for my child to receive any Advisory Committee on Immunization Practices (ACIP) recommended vaccine that they are due for.

If I do not want my child to receive a specific age appropriate ACIP recommended vaccine, I will list it/them below.

_____**Initials**_____

I give permission to Eastern Idaho Public Health and/or their designees to vaccinate the child named on this form. I have been offered a copy of EIPH's Notice of Privacy Practices.

Signature of Consent: _____ Date: _____

DO NOT WRITE BELOW THIS LINE

E. To be completed by person administering vaccine

Vaccination Date:			**Payer Source**	**Codes**	
EIPH Office: 1250 Hollipark Drive Idaho Falls, ID 83401 (208)533-3235			**Insurance** **Medicaid** **VFC**	**Per Shot** **90471** **90472 Units_____**	**Per Antigen** **90460 Units_____** **90461 Units_____**
Vaccine		**Lot Number**	**Provider Name**	**Site**	**Route**
90620	**Bexsero**			Left or Right Deltoid: Leg: Arm	IM
90700	**Dtap**			Left or Right Deltoid: Leg: Arm	IM
90633	**Hep A**			Left or Right Deltoid: Leg: Arm	IM
90744	**Hep B**			Left or Right Deltoid: Leg: Arm	IM
90651	**HPV**			Left or Right Deltoid: Leg: Arm	IM
90713	**IPV**			Left or Right Deltoid: Leg: Arm	IM/SQ
90696	**Kinrix**			Left or Right Deltoid: Leg: Arm	IM
90734	**Menactra**			Left or Right Deltoid: Leg: Arm	IM
90707	**MMR**			Left or Right Deltoid: Leg: Arm	SQ
90710	**Proquad (MMRV)**			Left or Right Deltoid: Leg: Arm	SQ

Child's Name:_____Patient's age:_____

Vaccine		Lot Number	Provider Name	Site	Route
90723	**Pediarix**			Left or Right Deltoid: Leg: Arm	IM
90647	**Pedvax**			Left or Right Deltoid: Leg: Arm	IM
90670	**Prevnar 13**			Left or Right Deltoid: Leg: Arm	IM
90680	**Rotateq**			Left or Right Deltoid: Leg: Arm	Oral
90715	**Tdap**			Left or Right Deltoid: Leg: Arm	IM
90636	**Twinrix**			Left or Right Deltoid: Leg: Arm	IM
90716	**Varicella**			Left or Right Deltoid: Leg: Arm	SQ
90686	**Flulaval 6 mo & up**			Left or Right Deltoid: Leg: Arm	IM
	OTHER			Left or Right Deltoid: Leg: Arm	IM/SQ
	OTHER			Left or Right Deltoid: Leg: Arm	IM/SQ
	OTHER			Left or Right Deltoid: Leg: Arm	IM/SQ

Screening Reviewed and Education Provided by:_____

Antigen Counseling Provided by Allison Barto PA-C

Initial: _____Date: _____

Checked In ☐ Scanned ☐ SuperBilled ☐ Check out ☐ Historical ☐

9/2017 TL