

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M or F

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parents Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mothers Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Living Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID:------------------------------

Insurance Company phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle any optional Vaccinations you would like to receive**:**

HPV, Flu Shot, Bexsero (Meningococcal Group B)

 **Medical History: The following will help us determine your eligibility for requested immunizations. Please answer to the best of your ability.**

|  |  |  |
| --- | --- | --- |
| **1.** Are you Pregnant or planning a pregnancy in the next 4 weeks?  | **YES** | **NO** |
| **2.** Are you currently ill with a fever, vomiting or diarrhea? | **YES** | **NO** |
| **3.** Have you received blood/plasma/immune globulin or had a vaccine in the last 4 weeks?  | **YES** | **NO** |
| **4.** Have you ever fainted, became dizzy or had a serious reaction after an immunization?  | **YES** | **NO** |
| **5.** Have you ever had a seizure disorder for which you require medication, a brainDisorder, Guillain-Barre Syndrome or any other nervous system disorder?  | **YES** | **NO** |
| **6.** Are you allergic to any medications, foods or vaccines and their components? (such as eggs, bovine protein,toxoids,sorbitol,neomycin,phenol,yeast,thimerosal,latex,protamine sulfate, formaldehyde, hypersensitivity to gelatin) | **YES** | **NO** |

 **ACKNOWLEDGEMENT/ RELEASE OF LIABILITY AND CONSENT TO RECEIVE IMMUNIZATION(S):**

* WRITTEN MD APPROVAL IS REQUIRED FOR CHILDREN UNDER THE AGE OF 8 YEARS FOR POLIO, RABIES AND MMR. YELLOW FEVER REQUIRES WRITTEN MD APPROVAL FOR PERSONS WITH MULTIPLE SCLEROSIS**,** CHILDREN UNDER 9 YEARS OR ADULTS OVER 59 YEARS. HEPATITIS A, B OR COMBO VACCINES ALSO REQUIRE MD APPROVAL FOR PERSONS WITH MS.
* **I** HAVE READ OR HAVE BEEN OFFERED A COPY OF THE CURRENT VACCINE INFORMATION SHEET PRIOR TO MY VACCINATION. I HAVE HAD A CHANCE TO ASK QUESTIONS AND I UNDERSTAND ALL THE RISKS AND BENEFITS INVOLOVED.
* I AGREE TO STAY IN THE AREA FOR 15 MINUTES AFTER RECEIVING MY VACCINATION TO ENSURE THAT NO IMMEDIATE REACTIONS OCCUR. I UNDERSTAND THAT IF I EXPERIENCE ANY SIDE EFFECTS IT WILL BE MY RESPONSIBILITY TO GOLLOW UP WITH MY PHYSICAN AT MY EXPENSE. LOCAL REACTIONS MAY INCLUDE BURNING, SWELLING, WHEAL, TENDERNESS OR BLISTERING AT SITE. GENERAL REACTIONS MAY INCLUDE FEVER, FATIGUE, DIARRHEA, NAUSEA, VOMITING, HEADACHE, ARTHRITIS, MALAISE AND MYALIA. SEVERE REACTIONS INCLUDE ANAPHYLAXIS, ENCEPHALITIS, GUILLAIN-BARRE AND FEBRILE CONVULSIONS.
* I UNDERSTAND THE VACCINE IS BEING PROVIDED BY FRANCISCAN WORKINGWELL. I EXPRESSLY RELEASE FROM ANY LIABILITY THE ABOVE NAMED ORGANIZATION AND INDIVIDUAL GIVING THE VACCINE(S). I, FOR MYSELF, MY HEIRS, EXECUTORS AND ASSIGNS HEREBY AGREE TO RELEASE THE SITE PROVIDER AND ITS EMPLOYEES FROM ANY AND ALL CLAIMS ARISING OUT OF, IN CONNECTION WITH OR IN ANY WAY RELATED TO MY RECEIPT OF THIS VACCINE(S) IN THEIR FACILITIES.
* I HAVE READ THIS CONSENT AND I AUTHORIZE FRANCISCAN WORKINWELL TO GIVE THE ABOVED NAMED VACCINE TO ME OR THE PERSON NAMED FOR WHICH I AM AUTHORIZED TO SIGN.
* I ACKNOWLEDGE THAT SOME VACCINES REQUIRE MULTIPLE DOSES AND/OR UP TO 2 WEEKS TO RECEIVE FULL PROTECTION.
* **ASSIGNMENT OF BENEFITS**: I HEREBY AUTHORIZE ANY INSURANCE WITH WHOM I HAVE APOLICY TO PAY DIRECTLY TO THE HEALTHCARE PROVIDERS ANY BENEFITS OTHERWISE PAYABLE TO ME. I HEREBY TRANSFER AND ASSIGN THE BENEFITS OF ANY POLICIES OF INSURANCE TO THOSE HEALTHCARE PROVIDERS WHO HAVE RENDERED SERVICES TO ME AND WHO ACCEPT SUCH ASSIGNMENT. I UNDERSTAND THAT I WLL BE FULLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL CHARGES NOT PAID BY MEDICAL INSURANCE. IF ANY AMOUNTS FOR WHICH I AM RESPONSIBLE BECOME DELINQUENT, I AGREE TO BE RESPONSIBLE FOR ANY EXPENSES PAID BY FRANCISCAN ALLIANCE AND HEALTHCARE PROVIDERS TO COLLECT THE AMOUNTS, INCLUDING REASONABLE ATTORNEY FEES.
* I UNDERSTAND THAT THERE MAY BE A DELAY, WHICH COULD BE MORE THAN 6 MONTHS, BETWEEN THE TIME I SIGN THIS CONSENT AND WHEN THE IMMUNIZATIONS ARE GIVEN TO MY CHILD. AS SUCH, I AGREE THAT IT IS MY SOLE RESPONSIBILITY TO MAINTAIN A COPY OF THIS CONSENT, TO NOTIFY THE SCHOOL OR FRANCSICAN IMMUNIZATIONS, AND TO PROVIDE AN UPDATED CONSENT IF MY ANSWERS CHANGE, OR MY CHILDS HEALTH CHANGES.

**PLEASE NOTE THAT IF YOU HAVE NOT ANSWERED OR FILLED OUT ALL INFORMATION WE WILL NOT VACINATE YOUR CHILD.**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature (parent or guardian if patient is under 18), Offered/Read HIPAA Privacy Practices Date

**Additional lines are for second and third dose consent.**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature (parent or guardian if patient is under 18), Offered/Read HIPAA Privacy Practices

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature (parent or guardian if patient is under 18), Offered/Read HIPAA Privacy Practices

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*Office USE ONLY\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

 \*staff always use a red check mark to identify vaccine was recorded in chirp on far right side of administered vaccine.

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| **CPT** **CODE** | **VACCINE/ VIS DATE/ROUTE &** **DOSAGE SCHEDULE** |  **SITE** | **LOT# & EXP.** | **CLINICIAN SIGNATURE & DATE**  | **DATE BILLED** | **PAID** |  |  |  |
| 90633- P PRI.77 **VFC.8** | HEPATITIS A **(1yr&up)** **VIS Date: 7/20/16** | Left or Right |  | 1 |  |  |  |  |  |
| 90632-APRI.103 |  **Dosage - IM .5 or 1CC**Schedule- now and 6-12 months  | Left or Right |  | 2 |  |  |  |  |  |
| 90744-P PRI.94  | HEPATITIS B **(birth&up)** **VIS Date: 7/20/16** | Left or Right |  | 1 |  |  |  |  |  |
|  **VFC.8** |  **Dosage – IM .5 or 1CC** | Left or Right |  | 2 |  |  |  |  |  |
|  90746-A PRI.120  | Schedule- now, 1 month, 6 month  | Left or Right |  | 3 |  |  |  |  |  |
|  | HPV9 Gardasil9 **(9yrs-26yrs)** **VIS Date: 12/2/16**  | Left or Right |   | 1 |  |  |  |  |  |
| 90651PRI.224 |  **Dosage – IM .5 or 1CC****Schedule’s –** | Left or Right |  | 2 |  |  |  |  |  |
| **VFC.8** | **(9yrs-14yrs )** -2 dose–now, 6months **(15yrs&up)** - 3 dose-now, 2 months,& 6months | Left or Right |  | 3 |  |  |  |  |  |
|  90620PRI.220 | Meningococcal B **(16yrs&up)** **VIS Date: 8/9/16** | Left or Right |  | 1 |  |  |  |  |  |
|  **VFC.8** |  **Dosage – IM .5CC**Schedule- 1 month apart | Left or Right |  | 2 |  |  |  |  |  |
|  90734 | Meningococcal (MCV4) **(11yrs&up)****VIS Date: 3/31/16**Schedule-  **Dosage – IM .5CC**1st dose at age 11 or 12 (6th grade)2nd dose at age 16 or (senior year) | Left or Right |   | 1 |  |  |  |  |  |
| PRI.284**VFC.8** | Left or Right |  | 2 |  |  |  |  |  |
| 90715PRI.138**VFC.8** | Tdap**(10yrs&up)****VIS Date: 2/24/15 Dosage – IM .5CC**[(Tetanus, Diphtheria, Pertussis)(https://www.cdc.gov/vaccines/hcp/vis/vis-statements/tdap.html)](https://www.cdc.gov/vaccines/hcp/vis/vis-statements/tdap.html) | Left or Right |  | 1 |  |  |  |  |  |
| 90710 | MMR-V **(LIVE)** (ProQuad) **(1yr-12yrs)****VIS Date: 2/12/18**Schedule-  **Dosage –SUBQ .5CC**1st dose at 1yr, 2nd dose at 4-6yrs old  \*\*DO NOT GIVE AFTER AGE 13  | Left or Right |  | 1 |  |  |  |  |  |
| PRI.326**VFC.8** | Left or Right |  | 2 |  |  |  |  |  |
|  90707 | MMR **(LIVE)** **(1yr&up)** **VIS Date: 2/12/18 Dosage –SUBQ .5CC**  | Left or Right |  | 1 |  |  |  |  |  |
| PRI.141**VFC.8** | Schedule- 1st dose at 1yr, 2nd dose at 4-6yrs old (may be given earlier, if at least 28 days after the 1st dose)  | Left or Right |  | 2 |  |  |  |  |  |
|   90716 | VARICELLA **(LIVE)** **(1yr&up)** **VIS Date: 2/12/18 Dosage –SUBQ .5CC**  | Left or Right |  | 1 |  |  |  |  |  |
| PRI.237**VFC.8** | Schedule- 1st dose at 1yr, 2nd dose at 4-6yrs old (may be given earlier, if at least 28 days after the 1st dose) | Left or Right |  | 2 |  |  |  |  |  |
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