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**VACCINE RESERVATION & CONSENT FORM FOR STUDENTS**

**School Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Clinic**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Complete all Information: We will verify your insurance coverage & eligibility of vaccination/s requested
*Please return form to school 2 weeks prior to clinic date. Forms will be faxed to Jen @ 412-563-8319 or 412-563-8016***

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| **PATIENT AND INSURANCE/PAYMENT INFORMATION****STUDENT NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AGE** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_\_\_\_\_\_\_ **(M)** \_\_\_ **(F)** \_\_\_**ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **APT** \_\_\_\_\_\_\_\_\_\_\_**CITY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **STATE** \_\_\_\_\_\_\_\_\_\_\_\_\_ **ZIP** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PHONE** (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **LAST 4 DIGITS of SOCIAL SECURITY NUMBER**\_\_\_\_\_\_\_\_\_\_**MOTHER’S NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FATHER’S NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OR **GUARDIAN’S NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**INSURANCE COMPANY’S FULL NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ID #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **GROUP #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**GUARANTOR FOR STUDENT** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **RELATIONSHIP TO STUDENT** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ADDRESS** IF DIFFERENT THAN ABOVE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**GUARANTOR PHONE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **GUARANTOR BIRTHDATE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PARENT/GUARDIAN CONSENT:** As the legal parent/guardian I give permission for my child to receive the following vaccine(s):
 (PLEASE CHECK)

**FLU (in season)**: \_\_\_\_\_\_\_\_ Injectable Flu vaccine (inactivated) (age 6 mo+)

**Energix-B:** \_\_\_\_\_\_\_\_ Hepatitis B (ages 0-19, 3 doses 0, 1, 6 mo)

**GARDASIL 9:** \_\_\_\_\_\_\_\_HPV (Human Papillomavirus)(ages 9-26, 2 doses 0, 6-12mo)

**MMR II:** \_\_\_\_\_\_\_\_ Measles, Mumps, Rubella (ages 12 mo+, 2 doses)

**MENVEO:** \_\_\_\_\_\_\_\_ Meningococcal “A,C,W,Y” Disease (ages 10-25)

**BEXSERO: \_\_\_\_\_\_\_\_** Meningococcal “B” Disease (ages 10-25, 2 doses at least 1 month apart)

**IPOL: \_\_\_\_\_\_\_\_** Polio (ages 2 mo- 6yrs, 4 doses – 4th dose given between 4-6yrs)

**DTaP: \_\_\_\_\_\_\_\_** Diphtheria, Tetanus, Pertussis/Whooping Cough (younger than 7 years of age)

**TDAP:** \_\_\_\_\_\_\_\_ Tetanus, Diphtheria, Pertussis/Whooping Cough (ages10+)

**VARIVAX:** \_\_\_\_\_\_\_\_Varicella (Chicken Pox) (ages 12 mo-12yr, 2 doses 3 mo. apart) (ages 13+, 2 doses 4 weeks apart)

**Consent:** I request and voluntarily consent that the above vaccine(s) be given to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of whom I am the parent or legal guardian, and I acknowledge that no guarantees have been made concerning the vaccine’s success. I have been given the Centers for Disease Control and Prevention Vaccine Information Statements. I have read these documents and have no further questions at this time. I understand the risks and benefits of the vaccines. I understand the possible side effects and warnings and precautions that should be taken into consideration prior to administration of the vaccine. I understand that I may cancel this permission at a later date by contacting the school.
Lastly, **I will complete the Patient Screening Questions on the back of this form.**

**Privacy Practices**: I acknowledge that Notice of Privacy Practices were made available to me.

**Financial Responsibility**: I have been notified that my insurance may deny payment entirely or partially for the vaccine or injection. If my insurance denies payment for the entire amount or for a partial amount, I agree to be personally and fully responsible.

**Pathways Wellness Program, LLC bills under Hart Medical Consulting, Dr. Bryce Palchick & does not charge for an office visit**

**Signature of Parent or Legal Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Printed name of above**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **PATIENT SCREENING INFORMATION PLEASE CIRCLE YES OR NO TO THE QUESTIONS BELOW:**1. **Is your child allergic to eggs, egg proteins, Gentamycin, latex, gelatin or thimerosal? Yes No**
2. **Has your child ever had a serious reaction to any vaccine? Yes No**
3. **Has your child ever had Guillain-Barѓe syndrome? Yes No**
4. **Does your child have a seizure disorder? Yes No**
5. **Does your child have asthma, recurrent or active wheezing or taken medicine for asthma (including inhalers) in the past 12 months? Yes No**
6. **Is your child under 18 years of age currently receiving aspirin or**

**aspirin containing therapy? Yes No**1. **Is your child pregnant or nursing? Yes No**
2. **Does your child have any diseases (e.g., cancer, lupus, or human immunodeficiency**

**virus [HIV] or acquired immunodeficiency syndrome [AIDS]) or take a medication** **(e.g., steroids or chemotherapy) that lowers the body’s resistance to infection? Yes No**1. **Has your child received a vaccine within the past 30 days?**  **Yes No**

**If yes, please list name of vaccine(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_1. **Does your child have any of the following long-term health problems? (PLEASE CIRCLE)**

 **heart disease lung disease kidney disease metabolic diseases (e.g., diabetes) other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. **Please let us know if your child has close contact with anyone who has a weakened immune system and must**

 **be in a protective environment (eg, an individual who has had a bone marrow transplant).**  **Please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NOTE FOR FLU VACCINE ONLY: If you answered YES to questions 1, 2, 3, or 4, your child should NOT receive an influenza vaccine through the school vaccination program. If you answered YES or left blank any of the questions 5 through 11, it is recommended that your child receive an injectable influenza vaccine**.****Allergies or medical alert: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Signature of Parent or Legal Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Printed name of above**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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**\*\*\*\*\*\*\*\*\*\* VACCINE(S) ADMINISTERED (To Be Completed By Vaccine Administrator) \*\*\*\*\*\*\*\*\*\***

**FLULAVAL** \_\_\_\_\_ 90686 **Other Vaccine** \_\_\_\_\_\_\_\_\_\_\_ CPT:\_\_\_\_\_\_\_\_

 **Energix-B** \_\_\_\_\_\_ 90744 **Menveo** \_\_\_\_\_ 90734 **BEXSERO** \_\_\_\_\_\_\_ 90620

 **GARDASIL 9** \_\_\_\_ 90651 **IPOL** \_\_\_\_\_\_ 90713 **DTaP**  \_\_\_\_\_ 90700

 **MMR II** \_\_\_\_\_\_\_ 90707 **VARIVAX**  \_\_\_\_ 90716 **TDAP** \_\_\_\_\_\_\_ 90715

**ADMINISTRATION CODE**: **INJECTABLE** \_\_\_\_\_\_\_90471 **Each Additional Shot** \_\_\_\_\_\_\_ 90472

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|  |  **FOR CLINIC USE ONLY** |
|  **Vaccine** | **Date of Service** | **Manufacturer** | **Lot #** | **Site/Route** | Dosage Vol | **VIS Date** |
| Flu Injectable |  |  |  | LD RD IM | 0.5ml | 8/15/2019 |
| Energix-B |  |  |  |  LD RD IM | 0.5 ml  | 8/15/2019 |
| Gardasil 9 |  |  |  |  LD RD IM | 0.5ml | 10/30/2019 |
| MMR II |  |  |  | LD RD SC | 0.5ml | 8/15/2019 |
| Menveo |  |  |  | LD RD IM | 0.5ml | 8/15/2019 |
| Bexsero |  |  |  |  LD RD IM | 0.5 ml | 8/15/2019 |
| Ipol |  |  |  |  LD RD IM | 0.5 ml | 10/30/2019 |
| DTaP |  |  |  |  LD RD IM | 0.5ml | 4/1/2020 |
| Tdap |  |  |  |  LD RD IM | 0.5ml | 4/1/2020 |
| Varivax |  |  |  |  LD RD SC | 0.5ml | 8/15/2019 |
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**Signature of Vaccine Administrator**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Rev 4/30/2020)