(Place patient label here if blank, or handwrite Name, DOB, & MRN)

Akron Children's

SCHOOL-BASED HEALTH CENTER VACCINE CONSENT FORM

Only circled vaccines will be offered at this event. See attached vaccine information sheets.

Influenza (Flu) DTaP/Tdap/Td Meningococcal (MCV4) Meningitis B MMR Varicella Polio Hepatitis B HPV Hepatitis A Pneumococcal Hib

School Name:

PLEASE COMPLETE ALL OF THE INFORMATION BELOW- Please print using ink (incomplete forms will not be accepted)

FIRST NAME (of student): LAST NAME (of student):

Birthdate: (mo/day/yr) Age: Grade:

PARENT/GUARDIAN INFORMATION

First Name: Last Name: Phone #: Relationship to Student:

VACCINATION & HEALTH REALTED QUESTIONS

1. Has your child ever had a life-threatening reaction to a vaccine of any kind? ☐ Yes ☐ No
2. Has your child ever had a condition called Guillain Barre Syndrome (GBS)? ☐ Yes ☐ No
3. Does your child have blood disorder such as hemophilia? ☐ Yes ☐ No
4. Has your child ever had seizures or another nervous system problem? ☐ Yes ☐ No

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT 330.543.7242

By signing below, I have read and understand the supplemental CDC Vaccine Information Sheets and my signature provides consent for my child to receive the designated vaccines as indicated on this form. I further agree that I will promptly inform the School-Based Health Center in writing of any changes in my child's physical health and any change in the custody of my child which affects my ability to provide this consent on behalf of my child.

REQUIRED INSURANCE INFORMATION

Insurance Name:

Insurance Address:

Subscriber Name / ID # Subscriber DOB:

MMIS: Group #:

☐ NONE, Please connect me to a Children's Financial Counselor

All services provided are billed to Insurance. If you do not have Insurance, Children's will connect you to Financial Assistance. No child is denied services for inability to pay.

Printed Name of Parent/Legal Guardian Date of Birth | Signature of Parent/Legal Guardian Date Time

Printed Name of Witness #1 to Signature if Verbal Consent *(health care personnel only)* | Signature of Witness #1 Date Time

Printed Name of Witness #2 to Signature if Verbal Consent *(health care personnel only)* | Signature of Witness #2 Date Time

SCHOOL-BASED HEALTH CENTER SERVICES

Throughout this document the use of the term "I" will refer to "I and/or my parents or guardians". The use of the term "me" "myself" or "my" shall refer to the student. The use of "Children's" will refer to Akron Children's Hospital, its physicians, nurses, other health care providers, employees, attending physicians and other physicians, and their assistants or designees.

I and/or my parent(s) or guardian(s) consent to let the physicians, nurses, other health care providers, and employees of Akron Children's Hospital, attending physicians and other physicians, or any of their assistants or deslgnees, do all things that may be needed for my child to receive the designated vaccines as indicated on this form. Children's is a teaching hospital and I understand and agree that people who are in training, including, but not limited to, fellows, residents, and students, may assist or participate in my care. I understand and agree that Children's may take photos, video, or audio recording of me and use them for clinical, internal education purposes, legal purposes and quality improvement purposes. I understand that the practice of medicine is not an exact science and that no guarantees have been made about the results of my examination or treatment at Children's.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: I agree to pay all bills for my care, including bills that insurance benefits do not pay. This includes bills for Children's, physicians, or other entities that provided services during my care. I authorize Children's to bill my insurance carrier and request that payments be made directly to Children's. I assign to Children's, my physicians, and other healthcare professionals involved in my care, all of my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, Tricare, any other program for which benefits may be available to pay Children's for the services provided to me, or other payments or Judgements. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payer regarding those services, I understand that a financial agreement will be established. I agree to cooperate and provide complete and accurate information as needed to establish my eligibility for such benefits.

PATIENT RIGHTS/PRIVACY INFORMATION: I understand I have the right to take part in decisions about my healthcare and plan for treatment. I have received, read, or had explained to me, and acknowledge receipt of the following documents and/or information, and all my questions have been answered.

Patient Rights and Responsibilities	Health Information Exchange	Advance Directive Information (Patients 18 yrs and older)	"An Important Message from Medicare" (Medicare patients)
Complaint/Grievance Procedure	Brochure HIPAA Notice of Privacy Practices	Free Hospital Care Information	"An Important Message trom Tricare" (Tricare patients)

AUTHORIZATION TO COMMUNICATE: I understand that Children's uses various communication methods including voice calls, computerized calls, computerized text message, email, fax, auto-dialed calls, and pre-recorded messaging for the purposes of sharing clinical/medical results, scheduling appointments, sending appointment reminders, obtaining patient feedback, and communicating/discussing financial responsibilities including past due balances I may owe. By signing this form, I am granting permission to Children's and its affiliates, clinical providers, and business associates, including any billing services, collection agencies, agents, or other third parties who may act on Children's behalf, to use all phone numbers and email addresses that I have supplied to contact me regarding this current visit and any future visits. I will be given the opportunity to opt out of future text, email, or phone communications at any time. I understand that my opting out of future text, email or phone communications will not affect, directly or indirectly, my right to receive health care services from Children's.

ALL PATIENTS COVERED BY MEDICAID: I was asked whether any insurance other than Medicaid may cover services provided by Children's. If there is other insurance coverage, I gave that information to Children's.

Privacy Practices
Children's Notice of Privacy Practices is available upon request at any School District building where services are provided. You can also view the Notice of Privacy Practices online at https://www.akronchildrens.org/pages/Privacy-Policy.html. Children's Notice of Privacy Practices describes how Children's may use and disclose you/your child's health information and how you can access you/your child's health information.

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