Vaccine Consent Form

Full, Legal Name of Student (*First Name Middle Initial. Last Name*) PLEASE PRINT	**Name of School**
Parent/Guardian Name (*First Name Middle Initial. Last Name*) **Relationship to Student**	**Homeroom Teacher / Grade**
Address **Email Address**	**Birth Date** (month / date / year) **Age** **Sex**
City **Zip Code**	**Home Phone #** **Cell Phone #**

Please CHECK ONE and fill out the following questions

Insurance ☐ **CHIP/STAR/Medicaid** ☐ **American Indian/Alaskan Native** ☐

Underinsured (insurance does not cover vaccines) ☐ **My child does not have health insurance** $5 Administrative Fee requested date of clinic ☐

Insurance Company: **Member ID:**

Policy Holder's Name: **Policy Holder's Date of Birth:**

The current health care laws require us to bill your insurance company for the vaccine. There will be no out of pocket expense for those insured.

Vaccine(s) to be given:

☐ HPV ☐ MCV 4 ☐ Men B ☐ Tdap ☐ Varicella ☐ Hep A ☐ Hep B ☐ MMR ☐ IPV

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL AURORA CONCEPTS AT 936-598-3296 TO SPEAK TO A NURSE.

I acknowledge that Aurora Concepts provided me and I have been afforded the opportunity to read the Notice of Privacy Practices and CDC Vaccine Information Statement for the vaccine(s) indicated on their website: www.auroraconcepts.net under the 'Patient Resources' tab.

I give permission to Aurora Concepts and their administrators to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Texas Department of Health policies, to assure optimal healthcare for my child. I hereby release Aurora Concepts, and my child's school district from any and all liability associated with the administration and potential side effects of the vaccine.

☐ **YES, I wish to participate** ☐ **NO, I do not wish to participate**

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____ Date _____

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

Clinic/Office Address:	Clinic/Office Address:	Clinic/Office Address:	Clinic/Office Address:	Clinic/Office Address:
Publication Date of VIS:	Publication Date of VIS:	Publication Date of VIS:	Publication Date of VIS:	Publication Date of VIS:
Date VIS Given:	Date VIS Given:	Date VIS Given:	Date VIS Given:	Date VIS Given:
Vaccine Given:	Vaccine Given:	Vaccine Given:	Vaccine Given:	Vaccine Given:
Date Vaccine Administered:	Date Vaccine Administered:	Date Vaccine Administered:	Date Vaccine Administered:	Date Vaccine Administered:
Vaccine Manufacturer:	Vaccine Manufacturer:	Vaccine Manufacturer:	Vaccine Manufacturer:	Vaccine Manufacturer:
Vaccine Lot Number:	Vaccine Lot Number:	Vaccine Lot Number:	Vaccine Lot Number:	Vaccine Lot Number:
Site of Administration:	Site of Administration:	Site of Administration:	Site of Administration:	Site of Administration:
Signature of Vaccine Administrator:	Signature of Vaccine Administrator:	Signature of Vaccine Administrator:	Signature of Vaccine Administrator:	Signature of Vaccine Administrator:
Title of Vaccine Administrator:	Title of Vaccine Administrator:	Title of Vaccine Administrator:	Title of Vaccine Administrator:	Title of Vaccine Administrator: