Franciscan HEALTH
IMMUNIZATION SERVICES

Child Consent form 17 & Under

Name: _____ Birthdate: _____ Age: _____

Social Security Number _____ Male or Female

Race: _____ Primary Language_____ Religious Pref_____

Address: _____ City: _____

State: _____ Zip: _____Phone Number: _____

Family Dr name: _____

Parent signing consent form Name_____Date of birth _____

Parent Social Security Number _____Employer: _____

Primary Insurance Company: _____ Member ID: _____

Group ID: _____

Insurance Company phone Number: _____ Policy Holder: _____ Birthdate: _____

Employer: _____

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

1. Are you currently ill with a fever, vomiting or diarrhea?	**YES**	**NO**
2. Have you ever fainted, became dizzy or had a serious reaction after an immunization?	**YES**	**NO**
3. 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**
4.Have you ever had a seizure or brain disorder requiring medication or diagnosed with Guillain-Barre' syndrome?	**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 A POLICYTO 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

Vaccine	Manufacturer	Route	Lot # exp	Staff signature
Full Dose Flu 0.5ml	GSK Sanofi	IM L Arm R L Thigh R		
FluMist	AstraZeneca	Nasal		