Vaccine Consent Form

Participation in Student Vaccination Program	
◯ YES, I wish to participate	◯ NO, I do not wish to participate

Full, Legal Name of Student (*First Name Middle Initial. Last Name*)	**Age**	**Birth Date** (month / day / year)	**Sex**
Student Social Security Number (*FOR SUPERIOR MEDICAID ONLY*)	**Name of School**		
Parent/Guardian Name (*First Name Middle Initial. Last Name*)	**Campus**		
Relationship to Student / **Email Address**	**Grade**	**Homeroom Teacher**	
Address			
City / **Zip Code**	**Home Phone #**	**Cell Phone #**	

Insurance Details

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

Underinsured (insurance does not cover vaccines) ◯ **My child does not have health insurance** $10/Vaccine Administrative Fee requested date of clinic ◯

Insurance Company: **Member ID:** **Group #**

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 (Required for 11-12 yo and college) ☐ Men B (Recommended 16-18 yo) ☐ Tdap ☐ Varicella

☐ Hep A ☐ Hep B ☐ MMR ☐ IPV ☐ Dtap ☐ Hib

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.

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

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

	1	2	3	4	5	6
Clinic/Office Address	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935
Publication Date of VIS						
Date VIS Given						
Vaccine Given						
Date Vaccine Administered						
Vaccine Manufacturer						
Vaccine Lot Number						
Site of Administration						
Signature of Vaccine Administrator						
Title of Vaccine Administrator						