

BENTON COUNTY HEALTH DEPARTMENT

PO Box 935

Warsaw, Missouri 65355

(660) 438-2876 Fax (660) 438-5746

Dear Parents/Guardians:

October 2023

The Benton County Health Department is working with your child's school to give the seasonal influenza vaccine to children at school. This vaccine will protect against all four influenza strains that are expected to circulate this year. We will hold vaccination clinics beginning this fall, and your child's school will let you know the specific dates.

Attached is a vaccine consent form for you to complete for your child to receive the flu vaccine at his/her school. If you'd like for your child to receive the flu vaccine at school, please fill out a Consent form ONLINE (see information below in box) OR fill out and sign the attached form (front and back) and **return** it to your school by **Wednesday, October 18, 2023**.

To complete the Payment information section of the form, here's what you need to do:

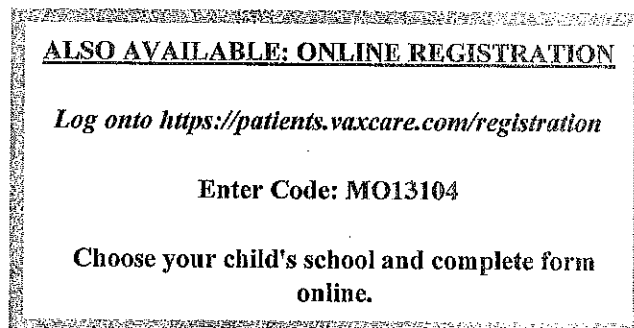
- If your child has Insurance, please complete the form and indicate what type of insurance your child has and provide all the requested insurance information.
**** Patient Responsibility Deductibles & Co-Pays MAY APPLY! ****
- If your child has Medicaid, please complete the form and indicate what type of Medicaid Company your child has and provide the DCN.
- If your child does not have insurance, please indicate on the form on the form, "NO Insurance".

If you have any questions about the vaccine or the vaccination clinics, please call the Benton County Health Department at 660-438-2876 from 8:00am to 5:00 pm. Please visit the CDC's influenza web site at <http://www.cdc.gov/flu/> for more information, especially for parents. Your child's health care provider also can answer your questions about the influenza virus. If you have concerns with your child receiving the vaccine at school; you can call and make an appointment at the Health Dept. in Warsaw or to their Primary Care Physician.

Our primary goal is to help ensure the children's health and safety and we are striving to assist you in getting the vaccines without having to miss school/work, pay an office copay or having to drive to another town.

Sincerely,

Tammie Heimsoth, RN, MSN, DON
Benton County Health Department



AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER
Services Provided on a Nondiscriminatory Basis

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Vaccine Consent Form

BENTON COUNTY HEALTH DEPT. - 2023 School Influenza

VaxCare has partnered with your healthcare provider to provide immunizations. All bills for vaccines will come from VaxCare and its physicians.

Clinic Info

Partner / Clinic Name Lincoln R-2	Date of Service / /
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Payment & Patient Info

Patient Name	Date of Birth	Gender	Phone
Address			Social Security #
Payer Name / Insurance Co. Name / Medicaid Co. Name		Member ID / DCN Number	Group ID
Insured Name	Insured Date of Birth	Ins. Gender	Relation to Insured

Notes

Check Out Doses

Check out and scan all ordered doses on the VaxCare Hub by the end of day.

Vaccine	Lot #	Site LD LL RD RL	Route IM SQ IN PO	Vaccine	Lot #	Site LD LL RD RL	Route IM SQ IN PO
Vaccine	Lot #	Site LD LL RD RL	Route IM SQ IN PO	Vaccine	Lot #	Site LD LL RD RL	Route IM SQ IN PO
Vaccine	Lot #	Site LD LL RD RL	Route IM SQ IN PO	Vaccine	Lot #	Site LD LL RD RL	Route IM SQ IN PO
Administrator Name		Administrator Signature		Administration Date			

Collect Consent

Consent for Use of Protected Health Information & Claims Assignment: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein. Vaccine Authorization: My signature on this form indicates that I have requested that the vaccine indicated below be administered to me by a VaxStation or VaxCare representative. I relieve VaxCare, the VaxCare partner, the administering Nurse and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out of or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association.

Neither I nor VaxCare shall be entitled to join or consolidate claims in arbitration or against other individuals or entities, or arbitrate any claims as a representative member of a class or in a private attorney general capacity. In the case of occupational exposure, VaxCare has patient's permission for blood testing for patient and employee safety alike. I have read or have had explained to me the information from the Vaccine Information Statement(s) and understand the risks (including adverse reactions) and benefits of the vaccine(s). I understand I will be responsible for payment for the below vaccine(s), these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. Additionally, I understand that if I am a self-pay or no-pay patient receiving services that all funds should be paid at the time of service and not remit to VaxCare. If consenting for another: I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine(s) administration.

Patient Signature	Date
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For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the person to be vaccinated ever had Guillian-Barre syndrome or any other neurological diseases?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	<input type="checkbox"/>	<input type="checkbox"/>

