



# 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](http://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: