Franciscan HEALTH
IMMUNIZATION SERVICES
325 S. Alabama Street Indianapolis, IN 46204 317-528-6374

School Name: _____ Grade: _____

TAX ID: 611630276
Group NPI: 1225327984
NPI: 1770595357

Name: _____ Birthdate: _____ Age: _____ Race: _____ Gender: M or F

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Parents Name: _____ Mothers Maiden Name: _____

Primary Insurance Company: _____ Member ID: _____ Group ID: _____

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

Insurance Mailing Address:_____

Patient Eligibility Screening (**circle if apply**) No health Insurance Coverage Medicaid American Indian/Alaskan Native

Please circle any optional Vaccinations you would like your child to receive:
HPV, Flu Shot, Bexsero (Meningococcal Group B)

IMPORTANT NOTICE

If you do not have insurance, or your insurance company does not cover vaccinations there is a $10 fee PER vaccination received.
If you cannot afford any or all the vaccinations please call our office to see if you qualify for assistance. 317-528-6374

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

1. Are you Pregnant or planning a pregnancy in the next 4 weeks?	**YES**	**NO**
2. Are you currently ill with a fever, vomiting or diarrhea?	**YES**	**NO**
3. Have you received blood/plasma/immune globulin or had a vaccine in the last 4 weeks?	**YES**	**NO**
4. Have you ever fainted, became dizzy or had a serious reaction after an immunization?	**YES**	**NO**
5. Have you ever had a seizure disorder for which you require medication, a brain Disorder, Guillain-Barre Syndrome or any other nervous system disorder?	**YES**	**NO**
6. 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**

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

Additional line for follow-up visit.

X_____ _____

Patient Signature (parent or guardian if patient is under 18), Offered/Read HIPAA Privacy Practices

**********Office USE ONLY**********

*staff always use a red check mark to identify vaccine was recorded in chirp on far right side of administered vaccine.

CPT CODE	VACCINE/ VIS DATE/ROUTE & DOSAGE SCHEDULE	SITE	LOT# & EXP.	CLINICIAN SIGNATURE & DATE	DATE BILLED	PAID
90633- P PRI.77 **VFC.8** 90632-A PRI.103	HEPATITIS A **(1yr&up)** **VIS Date: 7/20/16** **Dosage - IM .5 or 1CC** Schedule- now and 6-12 months	Left or Right		1		
		Left or Right		2		
90744-P PRI.94 **VFC.8** 90746-A PRI.120	HEPATITIS B **(birth&up)** **VIS Date: 10/12/18** **Dosage – IM .5 or 1CC** Schedule- now, 1 month, 6 month	Left or Right		1		
		Left or Right		2		
		Left or Right		3		
90651 PRI.224 **VFC.8**	HPV9 Gardasil9 **(9yrs-26yrs)** **VIS Date: 12/2/16** **Dosage – IM .5 or 1CC** **Schedule's –** **(9yrs-14yrs)** -2 dose–now, 6months **(15yrs&up)** - 3 dose-now, 2 months,& 6months	Left or Right		1		
		Left or Right		2		
		Left or Right		3		
90620 PRI.220 **VFC.8**	Meningococcal B **(16yrs&up)** **VIS Date: 8/9/16** **Dosage – IM .5CC** Schedule- 1 month apart	Left or Right		1		
		Left or Right		2		
90734 PRI.284 **VFC.8**	Meningococcal (MCV4) **(11yrs&up)** **VIS Date: 8/24/16** Schedule- **Dosage – IM .5CC** 1st dose at age 11 or 12 (6th grade) 2nd dose at age 16 or (senior year)	Left or Right		1		
		Left or Right		2		
90715 PRI.138 **VFC.8**	Tdap**(10yrs&up)** **VIS Date: 2/24/15** **Dosage – IM .5CC** (Tetanus, Diphtheria, Pertussis)	Left or Right		1		
90710 PRI.326 **VFC.8**	MMR-V **(LIVE)** (ProQuad) **(1yr-12yrs)** **VIS Date: 2/12/18** Schedule- **Dosage –SUBQ .5CC** 1st dose at 1yr, 2nd dose at 4-6yrs old **DO NOT GIVE AFTER AGE 13	Left or Right		1		
		Left or Right		2		
90707 PRI.141 **VFC.8**	MMR **(LIVE)** **(1yr&up)** **VIS Date: 2/12/18** **Dosage –SUBQ .5CC** Schedule- 1st dose at 1yr, 2nd dose at 4-6yrs old (may be given earlier, if at least 28 days after the 1st dose)	Left or Right		1		
		Left or Right		2		
90716 PRI.237 **VFC.8**	VARICELLA **(LIVE)** **(1yr&up)** **VIS Date: 2/12/18** **Dosage –SUBQ .5CC** Schedule- 1st dose at 1yr, 2nd dose at 4-6yrs old (may be given earlier, if at least 28 days after the 1st dose)	Left or Right		1		
		Left or Right		2		
90686 PI .39	FLU **Dosage 0.5cc IM** **VIS Date: 8/7/15**	Left or Right		1		
90696 PI .119	Kinrix (Dtap-IPV) **(up to age 6yrs)** **Vis 11/5/18** **Dosage 0.5cc IM**	Left or Right		1		