Monroe County Health Department

Monroe County, Indiana

Health Department	Futures Family Planning Clinic	Public Health Clinic
119 W. 7th Street (812) 349-2543	119 W. 7th Street (812) 349-7343	333 E. Miller Drive (812) 353-3244

August 24, 2021

Dear RBB Parents,

There will be a flu vaccination clinic and a second Pfizer COVID-19 vaccine clinic offered to students ages 12 and older at school, during the school day. If you wish for your student to receive this vaccine while at school, please complete the following steps:

1. Completely fill out the attached consent and health questionnaire. Do not forget to indicate any allergies your student may have. Consent must be signed by the parent or guardian of the student. **There is one consent for influenza vaccination and one consent for COVID vaccination.**

2. Please include your insurance information.

3. Check the date of your school's clinic paperwork deadline and return all the paperwork to your school by that date.

4. Please indicate if you would like your child to have the following vaccines. Please check both if applicable. The COVID vaccination if only for students aged 12 and older.

________ Influenza vaccination (all ages) ________ Pfizer COVID vaccination (12+)

The students that have received their first Pfizer vaccine at our previous visit will need to have a second dose. You will need to complete another consent form for that dose.
Thank you for taking steps to protect the health of your students and the community. If you have any questions, please call the Monroe County Public Health Clinic at 812.353.3244.

Sincerely,

Beth Carpenter RN
Monroe County Public Health Clinic

2021 SCHOOL CLINICS

SCHOOL NAME	TYPE OF CLINIC	CLINIC DATE	PAPERWORK DEADLINE
Edgewood Early Childhood Center	Flu		
Edgewood High School	COVID	Thursday, September 16, 2021	Friday, September 3, 2021
Edgewood High School	COVID & Flu	Thursday, October 14, 2021	Friday, October 1, 2021
Edgewood Intermediate School	Flu	Monday, October 25, 2021	Friday, October 8, 2021
Edgewood Junior High School	COVID	Thursday, September 16, 2021	Friday, September 3, 2021
Edgewood Junior High School	COVID & Flu	Thursday, October 14, 2021	Friday, October 1, 2021
Edgewood Primary School	Flu	Monday, October 25, 2021	Friday, October 8, 2021

Indiana Department of Health

COVID-19 Vaccination Patient Intake Form

First Name | MI | Last Name | DOB | Mobile Phone

Address | Email

City | State | Zip Code | Gender ☐ M ☐ F | Pregnant? ☐ Y ☐ N

Preferred Language:
- English
- Spanish
- Other
- Prefer not to Say

Preferred Ethnicity:
- Hispanic or Latino/Spanish
- Non-Hispanic or Latino/Spanish
- Prefer not to Say

Preferred Race:
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other Race
- Prefer not to Say

Employer Name

Is the patient sick today?

☐ Y ☐ N

Does the patient have allergies to medications, food, a vaccine component, or latex?

☐ Y ☐ N

Has the patient ever had a serious reaction after receiving a vaccination?

☐ Y ☐ N

Risk Factors (Circle all that apply)
- Obesity
- Over 65
- Diabetes
- Chronic Kidney Disease
- COPD
- Serious Heart Condition
- Sickle Cell Disease
- Other

Reason for Vaccination (Circle all that apply)
- Health Care Worker
- Long Term Care Employee
- Long Term Care Resident

Primary Medical Insurance Carrier

Policy Number

Group ID (If Present)

Policy Holder

PATIENT CONSENT FOR COVID-19 VACCINATION

Signature: | Date:

Notice of Privacy Practices

Signature: | Date:

Vaccine Information (Only for office personnel use)

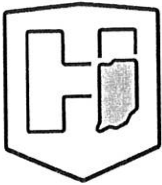
Vaccine Name | VIS/EUA Date | Dosage

CXV Code | Expiration Date | Administering Facility

Lot Number | Administration Site | Administration Date

Manufacturer | Administration Route

Indiana Department of Health — Division of Immunization



Indiana Department of Health

PATIENT CONSENT FOR COVID-19 VACCINATION

Explanation of Vaccination:

Vaccination for SARS COVID-19 is an intramuscular injection. Intramuscular injections are administered at a 90 degree angle to the skin, preferably into the deltoid muscle of the upper arm. Risks associated with this vaccination include mild side effects, such as fever, injection site pain, headache, muscle aches and fatigue, and a small percentage may still be vulnerable even after receiving the vaccine. This vaccine will require two (2) doses to work, and you will need to return for the second dose within the recommended time frame. This vaccine is presently available under an Emergency Use Authorization (EUA) issued by the U.S. Food and Drug Administration (FDA).

PATIENT'S CONSENT

I, the undersigned, certify that I am at least eighteen (18) years of age, have been informed about the vaccine purpose, procedure, and risks, and I have elected to receive. I understand this vaccination may be subject to reporting to a health information exchange or an immunization registry, who may share my vaccination information with others, and to my health care providers, for treatment purposes or as otherwise permitted by law. I have had the opportunity to have all my questions addressed before receiving the vaccine. I voluntarily consent and agree to receive the vaccination for COVID-19.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION:

I authorize the Indiana State Department of Health to disclose protected health information about me to my employer as described below:

Description of Information to be released: COVID-19 Vaccination Results

Purpose of Release: To ensure patient receives documentation of the COVID-19 vaccination.

Use and disclosure may be withdrawn: AUTHORIZATION: I understand that once the authorized information has been disclosed, it may not longer be protected by the HIPAA Privacy Rule. I understand that the covered entity seeking this authorization may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on whether I sign the authorization. I may revoke this authorization at any time, in writing,

except to the extent that action has been taken in reliance on this request. Written revocation will be effective upon receipt by the Indiana State Department of Health at 2 N. Meridian St., Indianapolis, IN 46204. Without my express revocation, this request will automatically expire one hundred and eighty (180) days after the date of signature.

Parent Consent for Monroe County HD Vaccination Clinic

Partner ID: ______ Partner Name: Monroe County Public Health Clinic

Clinic ID: ______ School Name: ______

Patient ID: ______ Consent ID:

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

① School and Student Information

STUDENT FIRST NAME | MI | STUDENT LAST NAME | AGE | GRADE | GENDER: ☐ M ☐ F

DATE OF BIRTH (MM•DD•YYYY) | SCHOOL NAME | HOME ROOM TEACHER

ETHNICITY: ☐ Amer. Indian / Alsk. Native ☐ Asian ☐ Black / Afr. Amer. ☐ Hawaiian / Pac. Islnd. ☐ Hispanic ☐ White ☐ Other______

STREET ADDRESS | APT/SUITE | CITY | STATE | ZIP

PARENT/GUARDIAN FIRST NAME | PARENT/GUARDIAN LAST NAME | PARENT/GUARDIAN PHONE

② Insurance Information (Please fill out completely!)

Please refer to the attached Accepted Payers list for the insurance companies that we are able to bill.

PRIMARY INSURANCE NAME | MEMBER / INSURED ID# | GROUP ID

RELATIONSHIP TO THE SUBSCRIBER/INSURED: ☐ Self ☐ Spouse ☐ Dependent

SUBSCRIBER/INSURED FIRST NAME | SUBSCRIBER/INSURED LAST NAME | SUBSCRIBER/INSURED DOB (MM•DD•YYYY) | GENDER: ☐ M ☐ F

By signing below, I consent to the use and disclosure of my child's personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed above to VaxCare for the services rendered. I understand I will be responsible for payment for the vaccines provided if my insurance company does not pay.

☐ MEDICAID STATE ID # ______ ☐ NO INSURANCE I have no insurance or Medicaid coverage for my child

By signing below, I request that payment of Medicaid benefits be made on my behalf to ______________ for any services provided to my child. I give ______________ permission to exchange my child's medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents, or other agents needed to determine benefits related to services provided. I agree to participate in treatment plans and to assignment of Medicaid benefits to ______________ for services rendered.

③ Authorization and 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 by 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.

SIGNATURE of PARENT or LEGAL GUARDIAN ______ DATE ______

FOR OFFICE USE ONLY - BLACK INK ONLY

Vaccination Details (Lot number must be recorded. Please adhere label or print clearly.)

☐ VFC ☐ VAXCARE

☐ Prefilled Syringe 0.5 mL (36 mths & older)

LOT#

SITE: ☐ LD ☐ RD ☐ LL ☐ RL Other______

DELIVERY: ☐ IM ☐ ID Other______

ADMINISTRATOR SIGNATURE | DATE (MM•DD•YYYY) | ADMINISTRATOR ID

Nurse/Administrator: I hereby attest by my signature that the patient (or guardian of patient) in question has been provided access to and explained the Vaccine Information Sheets and appropriate Immunization Schedules, and has given verbal and written consent for vaccination(s).

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(888) 829-8550 www.vaxcare.com

For patients receiving a Fluzone Standard, Fluzone Pediatric, or Fluzone High Dose vaccination: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or 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 person to be vaccinated sick today?	☐	☐
2. Does the person to be vaccinated have an allergy to latex, mercury, thimerosal, gelatin, chicken eggs/feathers, or other vaccine components?	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐
4. Has the person to be vaccinated ever had Guillian-Barre syndrome or any other neurological diseases?	☐	☐

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Accepted Payers

Indiana

PAYER

- AARP Secure Horizons (Flu, Pneumovax and Prevnar vaccines ONLY)
- Advantage Health Solutions (360 Plans ONLY)
- Advantra/Health America (Flu, Pneumovax, and Prevnar Vaccines ONLY)
- Advisory Health Administrators - Encore Health Network
- Aetna
- All Savers
- Allied Benefit Systems - Cigna
- Allied Benefit Systems - Encore Health Network
- Allied Benefit Systems - First Health
- Allied Benefit Systems - PHCS/Multiplan
- Allied Bénefit Systems-Aetna/Aetna Signature Administrators
- Allied National - Encore Health Network
- Allied National - PHCS/Multiplan
- Allied National - Sagamore Health Network
- Allwell - Managed Health Services (MHS)
- Ambetter - Managed Health Services (MHS)
- Anthem BCBS (Medicaid)
- Anthem/BCBS
- ASU Group - Encore Health Network
- Aultra Administrative Group - Encore Health Network
- Automated Group Administration - Encore Health Network

PAYER

- Auxiant - Encore Health Network
- BCBS Federal
- Benefit Administrative Systems - BAS
- Bind Benefits (UMR)
- Boon-Chapman Benefit Admin-Aetna Signature Administrators
- Care Improvement Plus (Flu, Pneumovax and Prevnar vaccines ONLY)
- Caresource
- Caresource (Medicaid)
- ChampVA
- Cigna
- Clover Health
- Community Health Direct - Encore Health Network
- Consociate Health TPA - Encore Health Network
- Continental Benefits - Aetna
- Core Benefits - Encore Health Network
- Cornerstone Benefit Administrators - Encore Health Network
- Coventry
- Custom Design Benefits
- Cypress Benefits - Encore
- Dunn & Associates
- Dunn & Associates Benefit Administrators - Encore Health Network

Accepted Payers

Indiana

PAYER

EBMS - Encore Health Network

Employee Plans - Encore Health Network

Encore - Cypress Benefits

Encore - Premier Healthcare

Encore Health Network (do NOT accept OneCare)

First Health

GEHA - United Healthcare Options PPO

Golden Rule (UnitedHealth One)

Great West Health - Cigna

Hawaii Mainland Administration - Encore Health Network

Health Alliance Medical Plans - Encore Health Network

Health America/Advantra (Flu, Pneumovax, and Prevnar Vaccines ONLY)

Health Assurance/Advantra (Flu, Pneumovax, and Prevnar Vaccines ONLY)

HealthSpan

Humana

Indiana Medicaid (Traditional)

Indiana University (IU) Health Plan

Indiana University (IU) Health Plans - Encore Health Network

IU Health Plan - Medicare Advantage

Kentucky Health Administrators - Encore Health Network

Key Benefit Administrators - Encore Health Network

PAYER

Lucent Health Solutions - Encore Health Network

Lutheran Preferred

Mail Handlers of America

Major Health Partners - Encore Health Network

Managed Health Services MHS - HIP/HCC/Hoosier Healthwise (Medicaid)

MCMC - Encore Health Network

MDwise HIP/HCC/Hoosier Healthwise (Medicaid)

Medben - Encore Health Network

Medicare B (Flu, Pneumovax and Prevnar vaccines ONLY)

Medicare Railroad (Flu, Pneumovax and Prevnar vaccines ONLY)

Medova Lifestyles Healthcare TPA - Encore Health Network

Meritain - Aetna PPO/POS II/Aetna Signature Administrators

Meritain - First Health

Meritain - PHCS/Multiplan

Meritain CBSA - Aetna PPO/POS II/Aetna Signature Administrators

Meritain CBSA - First Health

Meritain CBSA - PHCS/Multiplan

Multiplan

National Benefit Associates Buchta Trucking Trust - Encore Health Network

Nova Healthcare Administration - Encore Health Network

Oxford Health Plans

Accepted Payers

Indiana

PAYER

Paramount Preferred Options - Encore Health Network

Patoka Valley - Allied Benefit Systems

Patoka Valley - Dunn & Associates

Patoka Valley - Employee Plans, LLC

Patoka Valley - Healthsmart

Patoka Valley - Kentucky Health Administrators

Patoka Valley - Key Benefit Administrators

Patoka Valley - MedBen

Patoka Valley - Meritain

Patoka Valley - Meritain (CBSA)

Patoka Valley - North American Administrators (NAA)

Patoka Valley - Nova Healthcare

Patoka Valley - Pekin Insurance

Patoka Valley - ProClaim Plus

Patoka Valley - Professional Benefit Administrators

Patoka Valley - Southeastern Indiana Health Organization

Patoka Valley - UMR (Fiserv)

Patoka Valley - Underwriters Service Corp

Patoka Valley - Unified Group Services

Patoka Valley - WebTPA

Pekin Life Insurance Company - Encore Health Network

PAYER

PHCS

Physicians Health Plan (PHP)

Physicians Health Plan (PHP) - Encore Health Network

Premier Healthcare - Encore

Pro-Claim Plus - Encore Health Network

Professional Benefit Administrators

Professional Benefit Administrators - Encore Health Network

Professional Management Services

Sagamore

Self Insured Services Company (SISCO) - Encore Health Network

Signature Care - Parkview Health

Southeastern Indiana Health Organization

Southeastern Indiana Health Organization (SIHO) - Encore Health Network

Strategic Resource Company

Three Rivers Preferred (PPO Network ONLY)

Tricare East

UMR (United Medical Resources)

UMWA

Underwriter's Services Corporation (USC) - Encore Health Network

Unified Group Services - Encore Health Network

United Claim Solutions - Encore Health Network

The rates above are what we pay you for Risk Free administrations (and any At Risk doses we're able to successfully bill). A vaccine will be considered Risk Free if the following three criteria are met: 1) Check In – The patient is checked into our system via the VaxCare portal and receives an Eligible response. 2) Age Indication – The vaccine is given within the age indications of the manufacturer. 3) Check Out – The patient is checked out via the VaxHub within two business days.

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Accepted Payers

Indiana

PAYER

- United Health Integrated Services
- United Health One (Golden Rule)
- United Healthcare (UHC)
- United Mine Workers of America
- UnitedHealthcare Shared Services
- UnitedHealthcare Student Resources
- WebTPA - Encore Health Network
- WellCare (Medicare Advantage ONLY)
- Zelis - Global Care - Encore Health Network
- Zelis - PHX - Encore Health Network

PAYER

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2 Influenza vaccine

CDC recommends everyone 6 months of age and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**.
- Has ever had **Guillain-Barré Syndrome** (also called GBS).

In some cases, your health care provider may decide to postpone influenza vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

- Soreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13), and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's **www.cdc.gov/flu**