2022-2023 TDaP Vaccine Consent Form

THIS FORM MUST BE RETURNED

PLEASE COMPLETE THE INFORMATION BELOW
(Unreadable and incomplete forms may not be accepted.)

Full Legal Name of Student (First Name Middle Initial. Last Name) PLEASE PRINT			Student No.:	Name of School
Parent/Guardian Name (First Name Middle Initial. Last Name) / Relationship to Student			Grade	Homeroom Teacher
Birth Date (month/date/year)	Age	Sex	Ethnicity - (Check 1) ___ Hispanic or Latino ___ Not Hispanic or Latino	Race - (Check 1 or more) ____ American Indian or Alaska Native ____ Asian ____ Black or African American ____ Native Hawaiian / Pacific Islander ____ White ____ Other
Street Address			Email Address	
City			Zip Code	
Home Phone#	Cell Phone#			

Insurance (Check 1) ___ No Insurance ___ Medicaid ___ Privately Insured

You will not be billed, and there is no co-pay or deductible due. The service is offered at no cost to you! As always, answers are confidential.

HEALTH QUESTIONS: CHECK YES OR NO FOR EACH QUESTION

YES	NO	
____	____	1. Has your child had a fever within the last 24 hours?
____	____	2. Has your child ever had a serious reaction to any vaccine in the past or after a previous dose of diphtheria, tetanus, pertussis containing vaccine?
____	____	3. Has your child ever had Guillain-Barre syndrome or a history of siezures?
____	____	4. Does your child have any allergies to food, medication, or latex?

If **YES** to any of the above, please specify: ______________________________.

I have received, read and understand the CDC Vaccine Information Statement for the TDaP vaccine and the Notice of Privacy Practices. I have read these documents and understand the risk and benefits of the Tdap vaccine. I give permission to the State of Florida, Department of Health 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 Florida Department of Health policies, to assure optimal healthcare for my child.

☐ **Yes, I want my child to receive the TDaP vaccine.**

______________________________ Printed Name of Parent/Guardian

______________________________ Signature of Parent/Guardian

______________ Date

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

Date Given	Route/Site		Signature/Title
	RDT/IM	LDT/IM	

Nurse's Notes:

INITIATION OF SERVICES

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: ____

Name of Agency: Leon County Health Department - School Health Division

Agency Address: 2965 Municipal Way; Tallahassee, FL 32304

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

_______By initialing this line, I acknowledge that I have been provided with a Telehealth Informed Consent Informational Sheet and that I consent to the provision of some services to be provided by means of telehealth. I may withdraw my consent at any time by discontinuing the use of telehealth services without affecting my right to future care or treatment.

PART II **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations. Additionally, I consent to my health information being shared in the Health Information Exchange (HIE), allowing access by participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. If you choose not to share your information in the HIE, you may opt out by requesting and signing an HIE Opt-Out form.

PART III **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

______________________________	______________________________	______________
Client/Representative Signature	Self or Representative's Relationship to Client	Date
______________________________	______________________________	
Witness (optional)	Date	

PART VII **WITHDRAWAL OF CONSENT**

I, ______________________________ WITHDRAW THIS CONSENT, effective ____________________

Client/Representative Signature ... Date