CONSENT FOR SERVICES FORM

SUPER SHOT

Complete this form and bring to your appointment.
Every section of this form is required.

Patient's Information

Last Name	First Name, Middle Initial	Suffix	Birth Date (month/date/year)	Age	Sex

Complete Mailing Address	City	State	Zip

Demographic Information: Race (circle one)
American Indian/Native Alaskan Black Asian Hispanic White Unknown/Decline

Ethnicity (circle one)
Hispanic/Latinx Not Hispanic/Latinx Unknown/Decline

Parent/Guardian Information

Last Name	First Name, Middle Initial	Suffix	Email Address
			Primary Phone Number

Required Health Insurance Information

Check one:
- ☐ Private Insurance
- ☐ Medicaid (ex: Healthy Indiana Plan, Hoosier Care Connect, Hoosier Healthwise)
- ☐ No Insurance: I certify that I am not covered by any health insurance.

Insurance Company	Member ID	Group #

Policy Holder's Name	Policy Holder's Date of Birth	Patient's Primary Care Provider

Demographic Information

Number of people in my household: _____

My current household income is: ☐ below $11,800 ☐ $11,881 - $24,300 ☐ $24,301 - $ 36,450 ☐ $36,451 - $48,600 ☐ $48,601 - $60,750 ☐ $60,751 - $72,900 ☐ over $72,901

Medical Information **Please circle Yes or No for all questions. Answers are for the person getting the vaccine.**

1.	Is the patient allergic to any vaccine components such as eggs, gentamicin, arginine, gelatin, or MSG?	Yes	No
2.	Does the patient have any of the following: (mark all that apply) ☐ Chronic heart disease(s) ☐ Diabetes/metabolic disease/disorder ☐ Blood disease(s) ☐ Kidney disease/disorder(s) ☐ Liver disorders ☐ An inhaler that is used regularly ☐ Asthma/reactive airway disease/wheezing ☐ Weakened immune system, cancer, lupus, or HIV/AIDS ☐ A medication that lowers the body's resistance to infection		
3.	Has the patient had chickenpox disease?	Yes	No
4.	Is the patient on long-term aspirin therapy or taking Tamiflu®, Relenza®, amantadine, or rimantadine?	Yes	No
5.	Does the patient have close contact with severely immunocompromised persons who require a protective environment?	Yes	No
6.	Has the patient, a sibling, or a parent had a seizure; has the patient had brain or other nervous system problem?	Yes	No
7.	Is the patient pregnant or is there a chance she could become pregnant during the next month?	Yes	No
8.	Does the patient now have or had any history of Guillian-Barre Syndrome (GBS)?	Yes	No

All information I have provided on the consent for vaccination is true and correct. I am aware of the HIPAA Notice of Privacy Policy available at supershot.org. I am aware and understand the CDC Vaccine Information Statements for the vaccines the patient will receive today available at https://www.cdc.gov/vaccines/hcp/vis/index.html. I give permission to Super Shot to give the patient the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing, and storage according to Indiana Department of Health policies. By signing below I agree to the payment option for today's services that I have selected. I understand that if I have asked for a claim to be filed to my insurance company, I am responsible for charges not covered by my insurance plan and agree to pay them in full.

Printed Name of Patient _____ Patient's Signature _____ Date _____

For Official Use Only | Reviewed by: _____ Date: _____ | Signature of Administrator/VIS provided: _____ Date: _____

Vaccine	Manufacture & Lot #	Route/Site	Vaccine	Manufacture & Lot #	Route/Site	Vaccine	Manufacture & Lot #	Route/Site
Dtap / P / K			IPV / P / K			PCV 23		
Hep A			MMR / Q			Tdap		
Hep B / P			MCV4			Varicella / Q		
Hib			Men-B			Flu		IM/
HPV-9			PCV 13					