Vaccination Consent

Child's Name: **DOB:**

Please initial next to each vaccine you are authorizing your child to receive:

Required immunizations:

_____ DTaP (Diphtheria, Tetanus, acellular Pertussis)
_____ Tdap/Td (Tetanus, Diphtheria, acellular Pertussis)
_____ Polio
_____ Hib (Haemophilus B)
_____ PCV (Pneumococcal)
_____ Hepatitis A
_____ Hepatitis B
_____ MMR (Measles, Mumps, Rubella)
_____ Varicella (Chicken Pox)
_____ Human Papillomavirus (HPV)*
_____ Meningococcal ACWY

Per the Virginia Department of Health, the parent or guardian may elect for the child not to receive the HPV vaccine

Recommended Immunizations:

_____ Influenza (Flu)
_____ Meningococcal B

Please visit http://www.immunize.org/vis/ to find the Vaccine Information Statement for each vaccine, which will explain benefits and potential adverse effects of all vaccines.

Please check:

- ❑ ***I have received and reviewed the Vaccine Information Sheet (VIS). I understand all the benefits and potential adverse effects.***
- ❑ ***I have been given the opportunity to ask questions and have concerns addressed.***
- ❑ ***I authorize the licensed health care providers of Sentara to immunize my child.***

Parent/Legal Guardian (Print): _____

Parent/Legal Guardian Signature: _____

Relationship to Child/Student: _____ **Date:** _____

Reviewed by Vaccinator (Print): _____

Vaccinator Signature: _____ **Date:** _____

Sentara

Sentara Community Care Events Patient Registration Form

Communication Needs: ☐ Yes ☐ No Needs Interpreter: ☐ Yes ☐ No

Patient Demographics

Patient Name (Last, First): _____ Date of Birth: _____

Social Security Number: _____

Home Address:_____

City: _____ State: _____ Zip Code: _____ Main Telephone Number:_____

Legal Sex: ☐ Male ☐ Female

Gender Identity: ☐ Choose Not to Disclose ☐ Female ☐ Male ☐ Nonbinary ☐ Other
☐ Transgender Female (Male-to-Female) ☐ Transgender Male (Female-to-Male)

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Unknown ☐ Choose Not to Disclose

Emergency Contact

Name (Last, First): _____Relationship to Patient: _____
Main Telephone Number: _____

Guarantor Information

Who is responsible for this account? ☐ Self ☐ Employer ☐ Spouse ☐ Father ☐ Mother

Name: _____ SSN: _____DOB: _____Legal Sex: _____

Coverage Summary

Primary Insurance Information:

Plan Name: _____Member ID: _____Group #: _____

Policy Holder's Name: _____ Sex: ☐ Male ☐ Female

Policy Holder's SSN: _____ Policy Holder's DOB: _____

Subscriber ID: _____

Health Department
Vaccines for Children (VFC) Program
Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 3 years or longer depending on state law. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name :_____
Last Name First Name MI

2. Child's Date of Birth: __ __/__ __/__ __ __ __

3. Parent/Guardian/Individual of Record:_____
Last Name First Name MI

4. Primary Provider's Name:_____
Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC and state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-C is marked, the child is eligible for the VFC program. If column D, E, F or G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine			**Not eligible for VFC Vaccine**			
	A	**B**	**C**	**D**	**E**	**F**	**G**
Date	**Medicaid Enrolled**	**No Health Insurance**	**American Indian or Alaskan Native**	***Has health insurance that covers vaccines**	****Other underinsured**	*****Enrolled in FAMIS**	******Adult un/underinsured**

**Insured children under the age of 19 may receive the following vaccines using State free stock because of and in accordance with Code school requirements and/or current agency policy: DTaP, Hepatitus A, Hepatitis B, Hib, MMR, Pneumococcal conjugate, Polio, Rotavirus, MenACWY, Tdap, HPV and Varicella vaccines.*

- *Insured children receiving any other vaccines (e.g., Influenza, Men B vaccine) should receive chargeable vaccine.*

***Other underinsured are children that are underinsured but are not eligible to receive federal vaccine purchased with VFC funds because the provider or facility is not a FQHC/RHC. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

****Children enrolled in the Family Access to Medical Insurance Security Plan (FAMIS). These children are considered insured and are not eligible for federal vaccine purchased with VFC funds. The Virginia Department of Medical Assistance Services (DMAS) provides specific guidance on how FAMIS vaccine is purchased and administered through participating providers. However, these children may be served (using State/Section 317 stock) if they are receiving the following vaccines because of and in accordance with Code requirements and/or current agency policy: DTaP, Hepatitis A, Hepatitis B, Hib, MMR, Pneumococcal conjugate, Polio, Rotavirus, MenACWY, Tdap, HPV and Varicella vaccines.*

- *Insured children receiving any other vaccines (e.g., Influenza, Men B vaccine) should receive chargeable vaccine.*

*****Uninsured and underinsured adults are not eligible to receive federal vaccine purchased with VFC funds. However, they may be served if vaccines are provided by the state program to cover these non-VFC eligible patients.*

Screening Checklist for Contraindications to HPV, MenACWY, MenB, and Tdap Vaccines for Teens

YOUR NAME _____

DATE OF BIRTH ____/____/____
month day year

For parents/guardians: The following questions will help us determine if human papillomavirus (HPV), meningococcal conjugate (MenACWY), meningococcal serogroup B (MenB), and tetanus, diphtheria, and acellular pertussis (Tdap) vaccines may be given to your teen today. If you answer "yes" to any question, it does not necessarily mean your teen 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	don't know
1. Is your teen sick today?	☐	☐	☐
2. Does your teen have allergies to a vaccine component or to latex?	☐	☐	☐
3. Has your teen had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has your teen had a brain or other nervous system problem?	☐	☐	☐
5. Is your teen pregnant?	☐	☐	☐
6. Has your teen ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
7. Is your teen anxious about getting a shot?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your teen's immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your teen's vaccinations. If you don't have one, ask your healthcare provider to give you one with all of your teen's vaccinations on it. Keep it in a safe place and be sure your teen carries it every time he/she seeks medical care. Your teen will likely need this document to enter school or college, for employment, or for international travel.

Information for Healthcare Professionals about the Screening Checklist for Contraindications to HPV, MenACWY, MenB, and Tdap Vaccines for Teens

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references listed in ***Notes*** *below.*

NOTE: For supporting documentation on the answers given below, go to the specific ACIP vaccine recommendation found at the following website: www.cdc.gov/vaccines/hcp/acip-recs/index.html

1. **Is your teen sick today?** *(HPV, MenACWY, MenB, Tdap.)*

   There is no evidence that acute illness reduces vaccine effectiveness or safety. However, as a precaution, all vaccines should be delayed until moderate or severe acute illness has improved. Mild illnesses with or without fever (such as otitis media, "colds," diarrhea) and antibiotic use are not contraindications to routine vaccination.

2. **Does your teen have allergies to a vaccine component or to latex?** *(HPV, MenACWY, MenB, Tdap.)*

   Latex: An anaphylactic reaction to latex is a contraindication to vaccines with latex as part of the vaccine's packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). For details on latex in vaccine packaging, refer to the package insert (listed at www.fda.gov/vaccines-blood-biologics/vaccines/vaccines-licensed-use-united-states).

   An injection-site reaction (e.g., soreness, redness, delayed-type local reaction) to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component.

3. **Has your teen had a serious reaction to a vaccine in the past?** *(HPV, MenACWY, MenB, Tdap.)*

   Anaphylaxis to a previous vaccine dose or vaccine component is a contraindication for subsequent doses of corresponding vaccines (see question 2). Usually, one defers vaccination when a precaution is present unless the benefit outweighs the risk (e.g., during an outbreak). **A history of encephalopathy** within 7 days of DTP/DTaP is a contraindication for further doses of any pertussis-containing vaccine, including Tdap.

4. **Has your teen had brain or other nervous system problems?** *(Td/Tdap.)*

   Tdap is contraindicated in teens who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizures, vaccinate as usual. A history of **Guillain-Barré syndrome** (GBS) within 6 weeks of a tetanus-toxoid vaccine is a precaution; if the decision is made to vaccinate, give Tdap instead of Td.

NOTE: For summary information on contraindications and precautions to vaccines, go to the ACIP's General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html

5. **Is your teen pregnant?** *(HPV and MenB.)*

   MenB should not be given except to those with an elevated risk of exposure during pregnancy. HPV vaccine is not recommended during pregnancy. Injectable influenza vaccine, COVID-19 vaccine, Tdap, and RSV vaccines are explicitly recommended during pregnancy.

6. **Has your teen ever felt dizzy or faint before, during, or after a shot?**

   Fainting (syncope) or dizziness (presyncope) is not a contraindication or precaution to vaccination. However, for some people these can be a response to vaccination anxiety. People in adolescent and young adult age groups are more likely to experience syncope. CDC recommends that vaccine providers consider observing all patients for 15 minutes after vaccination. This is especially important for people with a pattern of injection-related syncope. For more information about vaccination-related syncope, see www.immunize.org/catg.d/p4260.pdf.

7. **Is your teen anxious about getting a shot?**

   Anxiety can lead to vaccine hesitancy or avoidance. Simple steps can ease a patient's anxiety about vaccination. Visit Immunize.org's "Addressing Vaccination Anxiety" clinical resources at www.immunize.org/clinical/topic/addressing-anxiety.

VACCINE ABBREVIATIONS

DTP = Diphtheria, tetanus, pertussis vaccine
DTaP = Diphtheria, tetanus, (acellular) pertussis vaccine
HPV = Human papillomavirus vaccine
MenB = Meningococcal serogroup B vaccine
MenACWY = Meningococcal serogroups A, C, W, Y
RSV = Respiratory syncytial virus
Td/Tdap = Tetanus, diphtheria, (acellular) pertussis vaccine

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Patient Label

Consent for Treatment/Financial Agreement AMBULATORY CARE

FIN

CONSENT FOR TREATMENT: Sentara Health (to include its direct and indirect subsidiaries named below*) ("Sentara") accepts the named Patient for diagnostic testing, emergency or inpatient treatment or outpatient surgery/treatment. The undersigned hereby consent(s) to Sentara providing its standard services, telehealth services and supplying or administering all services, diagnosing, treating, addressing care needs, supplies, medications (which may be dispensed from an alternate site pharmacy) and anesthesia ordered by Patient's or Hospital's physicians or their assistants, and to the performance of all procedures they deem advisable, and to the disposal of removed tissues. I consent to the recording, photography, closed circuit monitoring or filming for the purposes of treatment (will be in the medical record) or quality of care and teaching.

FINANCIAL AGREEMENT: The undersigned agree(s) to pay all charges made by (i) Sentara based upon Sentara's applicable current charge master and (ii) the other medical providers at their current rate for services rendered and (iii) for supplies used in providing care and treatment to the patient. The undersigned understand(s) that any prepayment is for estimated charges only and agree(s) that the final bill may be different. Sentara is not in the business of extending credit. All charges shall be paid when due (within 30 days of initial billing). The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If all charges are not paid when due, the undersigned agree(s) to pay 33 1/3% attorney's fees, or collection agency fees, which shall be deemed incurred upon referral for collection, plus costs, and interest at the current rate applicable by Statute to Virginia Judgments. The undersigned consents to Sentara's furnishing and accessing credit information with consumer reporting agencies. The return check fee is $25.00. Financial Aid is available to eligible individuals by calling the business office.

The Patient and the undersigned responsible parties are primarily liable for payment of Patient's account. It is their sole responsibility to comply in a timely manner with all requirements, and supply all information and documents necessary to obtain payment of benefits by any HMO or insurer, TRICARE, Medicare, Medicaid, Workers' Compensation carrier, governmental agency or other third-party source of benefits/payments. Sentara may submit claims to such payees as a courtesy only. It is NOT, unless by regulation or contract with the insurer or government agency, obligated to do so. The undersigned understand(s) that hospital fees, and professional fees for Emergency Physicians, Radiologists, Pathologists, and other physicians' services are billed separately. Sentara Health* reserves the right to charge the undersigned $40 for missed appointments and such charge will not be covered by insurance or a FSA/HSA. Should there be cumulative payments to Sentara more than the charges incurred for Patient's admission or treatment, it is understood and agreed that the excess may be applied by Sentara to any of the Patient's outstanding accounts resulting from other Sentara admissions and/or treatments. The undersigned agrees to pay Sentara for laboratory testing ordered for them by their physician but performed in a Sentara reference laboratory.

COMMUNICATIONS: The Patient and the undersigned responsible parties each authorize Sentara (including its representatives and agents) to contact them by phone using artificial voice, pre-recorded messages and/or automated dialing systems at any phone number associated with them or their personal representatives, including wireless numbers, in connection with any matter relating to my treatment, payment, or account, or to advise of products or services that may be of interest. Further calls or messages can be declined by following the reasonable instructions specifically provided by Sentara. There is no requirement to agree to receive such phone calls and messages to receive treatment or other Sentara services. By providing any email address and/or cell phone number, each authorizes Sentara (including its representatives and agents) to send them information, reminders, and messages using those means of communication. Understanding that email and text message are not completely secure means of communication (due to the potential for these messages to be addressed to the wrong person or accessed improperly while in storage or during communication) but that they allow Sentara to communicate more efficiently and provide better service, each further authorizes Sentara to send unencrypted messages using these means. Carrier rates may apply.

ASSIGNMENT OF BENEFITS from claims made by or on behalf of patients for any insurance coverage, workers' compensation, governmental agency or disability benefits, in an amount equal to the full amount of all charges (including attorney's fees, collection agency fees, costs and interest) due hereunder is made to Sentara and medical providers without offset. It is agreed that such ASSIGNMENTS SHALL NOT BE REVOKED. Sentara and medical providers are given a lien in like amount and are authorized to receive direct payment of all assigned benefits/proceeds. Any attorney, insurance carrier, responsible employer or agency handling or disbursing such benefits or proceeds is ordered, authorized, and directed to withhold and promptly pay over to Sentara and medical providers the lesser of the full amount of their charges or the total net proceeds or benefits available without offset.

NOTICE OF DEEMED CONSENT FOR INFECTIOUS DISEASE TESTING: Virginia Code Section 32.1-45.1 provides that when either a person providing health care service or a patient is directly exposed to the body fluids of the other in a way that may transmit human immuno-deficiency virus or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

Personal Valuables: Sentara shall not be liable for damage or loss of property not deposited with it. (_____initials_____date)
Communication Assistance: I and/or my companion(s) have been offered Communication Assistance on this date.
Accepted (_____initials_____date) ● **Declined** (_____ initials_____date)
Notice of Privacy Practices: I have been offered a copy of Sentara's Notice of Privacy Practices on this date.
Accepted (_____initials_____date) ● **Declined** (_____ initials_____date)
Your Patient Rights and Responsibilities/Notice of Nondiscrimination: I have been offered a copy of Sentara's Your Patient Rights and Responsibilities/Notice of Nondiscrimination on this date. **Accepted** (_____initials_____date) ● **Declined** (_____ initials_____date)

DRUG AND DEVICE DISCOUNTS: In some cases, Sentara may be able to obtain reimbursement for some of your medications and/or medical devices from the manufacturer. In the event this occurs, the charge for the medication or medical device is adjusted on your bill for that hospital stay. Your signature on this form gives Sentara permission to sign your name on the application, if needed, and view and release any personal, medical, and/or financial information required by the Patient Assistance Programs to apply for a free or discounted drug or device This information will remain confidential within Sentara and will only be given to the drug and device manufacturing companies sponsoring the program.

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Consent for Treatment/Financial Agreement
AMBULATORY CARE

FIN

I acknowledge that this consent is voluntary and that it may be revoked by me in writing at any time except to the extent that action has already been taken in reliance on it. Unless revoked, this consent shall be valid for one (1) year from the date of authorization, or until final determination of any benefits application as described above, whichever is later; however, the consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.

ENTIRE AGREEMENT CLAUSE: EACH UNDERSIGNED REPRESENTS THAT THEY HAVE READ AND FULLY UNDERSTAND THE MEANING AND EFFECTS OF THIS ENTIRE AGREEMENT, AND THAT SENTARA HAS MADE NO REPRESENTATION NOT HEREIN SET FORTH. ANY CHANGES TO THIS TYPED AGREEMENT MUST BE MADE THROUGH A SEPARATE WRITING SIGNED BY ALL PARTIES. CARBON COPIES AND PHOTOCOPIES HEREOF ARE DUPLICATE ORIGINALS FOR ALL PURPOSES.

Date/Time	Patient Signature	Other responsible party signature	Relationship

☐ No Responsible Person Available (If checked, two witness signatures required.)
☐ Patient unable to sign but has acknowledged an understanding of the above and consents to the undersigned witness printing their name.
☐ Verbal consent to treat obtained from responsible party_____.

Employee Witness Signature	Date / Time	Employee Witness Signature	Date / Time

*Sentara Health includes: Sentara Medical Group; Martha Jefferson Medical Group, LLC; Albemarle Physician Services - Sentara, Inc.; RMH Medical Group, LLC; Dominion Health Medical Associates, Ltd.; Sentara Hospitals (including Sentara Williamsburg Regional Medical Center, Sentara Careplex Hospital, Sentara Leigh Hospital, Sentara Norfolk General Hospital, Sentara Obici Hospital, Sentara Virginia Beach General Hospital); Sentara Princess Anne Hospital; Martha Jefferson Hospital; Sentara RMH Medical Center; Potomac Hospital Corporation of Prince William; Sentara Albemarle Regional Medical Center; and Halifax Regional Hospital, Inc; Hospital for Extended Recovery; Sentara Enterprises; Sentara Advanced Imaging Solutions, LLC; Sentara Life Care Corporation; Sentara Reference Lab Solutions, LLC; Sentara Therapy Solutions, LLC.; SMG Anesthesia Specialists, LLC; SARMC Anesthesia Specialists, LLC; Proprium, LLC; and Velocity Urgent Care, LLC.