Branch No.: _____ Clinic No.: _____

MENINGITIS B CONSENT FORM

☐ Student Account *(I give permission to bill my student account for this health service charge)*

☐ c. Meningitis B – Bexsero 90620/90471 DX V03.89 $ ___ . ___

TOTAL PAYMENT

$ ___ . ___

INSURANCE REIMBURSEMENT SHOULD BE SENT TO PARTICIPANT.

Corporate Address: 7227 Lee DeForest Drive • Columbia, MD 21046
Phone No. 866-211-0001
Maxim Health Systems, LLC, Tax ID No. 52-1968516, provides services in AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MS, MT, NC, ND, NE, NJ, NM, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, and WY.
Maxim Healthcare Services, Inc., Tax ID 52-1590951, provides services in AZ, MO, NH, NV, and RI.
Maxim of New York, LLC, Tax ID 06-1643257, provides services in NY.

Participant's Name (Last, First, M.I.) D.O.B. (MM/DD/YY) Age Sex (M/F)

School/Institution Name School Phone (include area code)

Student ID (if different from S/S No.) Home Phone (include area code)

Home Address City State Zip

Year: ☐ Fr ☐ So ☐ Jr ☐ Sr ☐ Grad Living: ☐ On Campus ☐ Off Campus ☐ Faculty ☐ Staff

CONSENT FOR SERVICES, MEDICAL RECORDS RELEASE, & HIPAA PRIVACY INFORMATION

I have read the precautions and contraindications associated with the vaccine(s) checked above. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. For participants attending an educational institution (school/college) or residing in Senior Living, Assisted Living and/or Skilled Nursing Facility Settings: A copy of this consent may be provided to the institution/Facility for inclusion in your medical record and continuity of your education and/or treatment/care at the Facility. I am requesting that the immunization(s) be given to me or the person named below for whom I am the legal guardian. I for myself, my heirs, executors, personal representatives and assigns, hereby release Maxim, any college/university, corporation, physician, and/or medical director and their respective affiliates, subsidiaries, divisions, directors, officers, shareholders and employees, from any and all claims arising out of, in connection with or in any way related to the services or vaccine(s) provided. I acknowledge that such parties shall not at any time or any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection therewith. Maxim will use and disclose your personal and health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared and provided you with a detailed NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICE to help you better understand our policies in regards to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices. I agree to remain in the general area for at least 15 minutes after receiving the vaccine.

Signature/Legal Guardian Print Name Date

_____ I understand that I am to provide a copy of this form to my physician and/or health care provider for my permanent records.
Initial

Precautions and Contraindications: ***Please mark YES or NO for each question.***

General Screening Questions	***YES***	***NO***
1. Are you exhibiting symptoms other than mild coughing, runny nose and/or diarrhea? (Individuals with a mild illness can usually get vaccinated)	☐	☐
2. Do you have allergies to medications, food, or any vaccine?	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐
4. Do you have a history of Guillain-Barré Syndrome?	☐	☐
5. Are you breast feeding?	☐	☐
6. Have you ever had an anaphylactic-type reaction to latex?	☐	☐
7. Are you pregnant or do you suspect you are pregnant?	☐	☐
Complete for Meningitis vaccine: (see attached for adverse reaction info)		
8. Have you ever received the Menactra, Menomune or Meningitis B (Bexsero), (Trumenba) vaccine before? If yes, when?_____	☐	☐

MENINGITIS VACCINE ADVERSE REACTIONS - Mild Problems: Headache, nausea, pain at the injection site, injection site swelling, hardening at the injection site, redness at injection site, bruising, tiredness, fever, muscle and joint pain. Syncope (fainting) can occur in association with administration of BEXSERO.

Severe allergic reactions may include high fever or unusual behavior. If a serious allergic reaction occurred it would happen within a few minutes to a few hours after the shot. Other serious allergic reactions include difficulty breathing, weakness, hoarseness or wheezing, a fast heartbeat, hives, dizziness, paleness, or swelling of the throat.

Vaccine	Lot No.	Exp. Date MM/DD/YY	Route/Site (check site)	Dosage - Age	Today's Dose	Mfg.	VIS Distributed	Next Dose
Meningitis Bexsero			Intramuscular Deltoid: ☐ L ☐ R	0.5 mL*	☐ 1 ☐ 2	Novartis	☐ Yes ☐ No	1 month after 1st dose

*Refer to PI for Age Specifications

Nurse Administering Vaccine(s) Print Name Date