HEALTH HEROES of Georgia

8317 Office Park Dr.
Douglasville, GA 30134
706.623.7507
GA@healthherousa.com
www.healthherousa.com

Health Hero Partner(s)/Parent(s)/Guardian(s):

We would like to express how excited we are in having the opportunity and invitation to host school located vaccine clinic(s) (SLVC's) within your school(s) and the state of Georgia. Our program is independently owned and operated and adheres to all compliances required by the state. We have been approved by Georgia Department of Public Health (GDPH) to operate within all school systems of Fulton, Cobb, Gwinnett, Douglas, Newton, Rockdale, and Dekalb counties.

Our program was created and specifically designed for students with working parent(s)/guardian(s) and school systems both public and private that are impacted by involuntary absenteeism and/or leave from work attributed to preventable sickness.

When asked, "Why Health Heroes?" – we could provide over eight (9) years of success stories and accolades from 14 states that we currently operate in however, we attribute our accomplishments/success to four (4) of our core C's.

Our 4 Core C's

- **Cost** – There's NO out of pocket for the parent nor the student and/or school/faculty. We bill the appropriate insurance provider directly.

- **Convenience** – Children don't have to miss school which could impact attendance and grade performance nor do parents have to take unnecessary time off work.

- **Compliancy** – We only use ACIP recommended and FDA approved vaccines. Our program has proven to aide in improving students and schools attendance matrixes. As a combo to school(s) participating in our Influenza SLVC's - we offer our Spring Compliancy SLVC's in efforts of assisting those schools in meeting state required vaccination(s)(TDAP & Meningococcal A, C, W, Y & B) of students. We also upload all vaccine records we administer into the state of Georgia registry – GRITS.

- **Commitment** – Our pledge, focus and efforts are to help keep students/people, our families/households and communities healthy while you keep them smart and prepare them for the workforce. We offer vaccination to all students with Medicaid, uninsured, underinsured as well as with most private insurance providers. All students must have a signed Health Heroes of Georgia consent form by legal parent/guardian with insurance member ID number in the appropriate section.

We believe that it is through collective efforts that we can keep everyone healthier and achieve optimal results. We pride ourselves in being professional, friendly and as efficient as possible to maximize our efforts and to ensure a successful SLVC or clinic. Collaborations and partnerships with all vested personnel is critical to our success and in meeting expected expectations.

If you have additional questions or concerns, please contact your respected school nurse and/or Health Heroes of Georgia SLVC Coordinator – Rachel Morrison via email at GA@healthherousa.com or by phone at (706) 623-7507. You can also find more information at www.healthherousa.com.

We hope to see your child in clinic!

Sincerely,

Health Heroes of Georgia

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Influenza (FLU) Vaccine Consent Form

School Name:_______________________________ **Clinic Date** ___________________________

PLEASE COMPLETE ALL OF THE INFORMATION BELOW - **Please print using ink** (Incomplete forms will not be accepted)

FIRST NAME		LAST NAME	
Gender: Male Female	Birthdate: (mo/day/yr) / /	Age	Homeroom Teacher / Grade
Address	Relationship with the patient: Father Mother Guardian	Home Phone # ( ) -	Cell Phone # ( ) -
City	Zip Code State	Student Race/Ethnicity: (Circle one) African American/Black White Alaskan/Native American Asian Hawaiian/Pacific Islander Hispanic/Non- Hispanic or Other	

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.
Please fill out the following questions pertaining to your child's Health Insurance: **IT IS CONSIDERED FRAUDULENT TO CLAIM UNINSURED IF YOU HAVE INSURANCE.**

Parent / Guardian Information		
First Name	Last Name	Relationship to Patient

REQUIRED INSURANCE INFORMATION (MUST CHECK AN APPROPIATE BOX)

MEDICAID & MANAGED CARE ORGANIZATIONS

AMERIGROUP	CARE SOURCE	PEACH STATE	WELL CARE	STRAIGHT MEDICAID	OTHER: (PLEASE SPECIFY INSURANCE PROVIDER NAME)

PATIENT'S MEDICAID MEMBER ID #	
CURRENTLY HAVE NO INSURANCE * NOTE: IT IS FRAUDULENT TO CLAIM UNINSURED IF YOU HAVE INSURANCE	

PRIVATE INSURANCE COMPANIES

AETNA	BCBS	CIGNA	CORE SOURCE	HUMANA	MEDICAL MUTUAL	TRI-CARE	UHC	OTHER: (PLEASE SPECIFY INSURANCE PROVIDER NAME)

CARDHOLDER'S FIRST NAME	CARDHOLDER'S LAST NAME	CARDHOLDER'S DATE OF BIRTH
		M M / D D / Y Y Y Y

INSURANCE MEMBER ID # (INCLUDE ALPHA PREFIX, IF SHOWN ON CARD)	

VACCINATION & HEALTH-RELATED QUESTIONS

#	Question		
1	Has your child ever had a life-threatening reaction(s) to the flu vaccine in the past?	YES	NO
2	Has your child ever had Guillain-Barre' syndrome?	YES	NO
3	Does your child have an allergy to eggs?	YES	NO
4	Does your child have a blood disorder such as hemophilia?	YES	NO
5	Will this be the first time your child has ever received a flu vaccination?	YES	NO

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL US AT 706-623-7507 TO SPEAK TO A REPRESENTATIVE.

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release the school system, Health Heroes of Georgia Corp. & subsidiaries, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. Clinic dates can be obtained from the school. I understand that the health-related information on this form will be used for insurance billing purposes I give permission to Health Heroes of Georgia Corp. to discuss or appeal any claims with my insurance carrier on my behalf.

______________________ Signature of Parent/Guardian ______________________ Printed Name of Parent/Guardian ______________________ Date

VIS CDC IIV 08/15/2019 **INFLUENZA**
LOT Number: **EXP Date:**
RN #___________________ Date:___________________
AREA FOR OFFICIAL ADMINSTRATION USE ONLY

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