Office User Only

Faculty Vaccine Consent Form

Full, Legal Name (First Name Middle Initial. Last Name)	**Name of School**
Email Address	**School Campus**
Address	**Birth Date** (month / day / year) **Age** **Sex**
City **Zip Code**	**Primary Phone #** **Secondary Phone #**

Insurance Company: **Member ID:** **Group #:**

Policy Holder's Name: **Policy Holder's Date of Birth:**

The current health care laws require us to bill your insurance company for the vaccine. There will be no out of pocket expense for those insured.

Vaccine(s) to be given:

☐ FLU ☐ PCV13 ☐ PCV23 ☐ Tdap ☐ Shingrix ☐ Hep A ☐ Hep B ☐ B12 ☐ Lipo-C ☐ Labs

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR PRIMARY CARE PHYSICIAN OR CALL AURORA CONCEPTS AT 936-598-3296 TO SPEAK TO A NURSE

I acknowledge that Aurora Concepts provided me and I have been afforded the opportunity to read the Notice of Privacy Practices and CDC Vaccine Information Statement for the vaccine(s) indicated on their website: www.auroraconcepts.net under the 'Patient Resources' tab.

_____ _____ _____

Printed Name Signature Date

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

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Clinic/Office Address	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935
Date VIS Given						
Vaccine Given						
Date Vaccine Administered						
Vaccine Manufacturer						
Vaccine Lot Number						
Site of Administration						
Signature of Vaccine Administrator						
Title of Vaccine Administrator						