Sedgwick County Health Department VACCINATION CONSENT FORM

Based on vaccination records available to the school nurse and the Health Department

Student Information

Last Name	**First Name**	**Date of Birth**	**Age**	**Phone**
Street Address		**City**	**State**	**Zip**
Gender M____ F____	**Hispanic or Latino** Yes_____ No____	**School**		
Race Asian Black/African American Caucasian Native American/Alaskan Native Native Hawaiian/Pacific Islander Other				
Authorization to Contact: Please initial and check all that apply: Initial _____ This information may be used to contact me regarding appointments or vaccination reminders. ☐ Phone ☐ Text ☐ Mail ☐ Email (please provide email address) _____				
Does the student have health insurance? **Yes** **No** Insurance company_____ Policy Number_____ Policy Holder Name_____				

Screening Questionnaire

1.	Is the student currently sick or experiencing a fever?	Yes	No
2.	Has the student had a severe reaction to a vaccine in the past?	Yes	No
3.	Does the student have any known severe allergies to medications, foods, latex, or a vaccine component?	Yes	No
	3a. If yes to above, please list allergies and reaction:		
4.	Has the student received any vaccines within the last 4 weeks?	Yes	No
5.	Has the student, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problems?	Yes	No
6.	Does the student have a long-term health problem with their heart, lungs (including asthma), kidneys, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?	Yes	No
7.	Does the student have an immune system problem such as cancer, leukemia, HIV/AIDS?	Yes	No
8.	Does the student's parent or sibling have an immune system problem?	Yes	No
9.	In the past 6 months, has the student taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	Yes	No
10.	In the past 12 months, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	Yes	No
11.	Is the student pregnant?	Yes	No
12.	What was the first day of the student's last menstrual cycle? Date:_____	Not Applicable	
13.	Has the student ever fainted or experienced dizziness after receiving a vaccine?	Yes	No

I give permission for the student above to receive the following vaccinations. Check the appropriate box and initial.

☐ **Yes/*Initial*:_____ All vaccinations required for my student's age and grade level *and* vaccinations that are recommended by the Centers for Disease Control.**

☐ **Yes/*Initial*:_____ All vaccinations required for my student's age and grade level.**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

Yes/Initial:_____ I acknowledge that a copy of Sedgwick County's Notice of Privacy Practices dated September 2022 has been made available to me prior to my signing this Consent Form. My signature below gives permission for my child to be vaccinated at school and authorizes the electronic exchange of information to the Kansas Immunization Registry. I also authorize the mutual exchange of my child's vaccination records between the school nurse and the Sedgwick County Health Department.

INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION

Yes /Initial:_____ I request that payment of authorized Medical Benefits billed to insurance (including Medicare, Medicaid, and KanCare) be made on behalf of the student to Sedgwick County Health Department for any services furnished to the student by that entity. I authorize any holder of the student's medical information to release to the Centers for Medicare and Medicaid services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand and acknowledge that Sedgwick County Health Department files insurance as a courtesy. I further understand and acknowledge that if all program requirements are met by the provider but payment is not made by Medicaid and/or any other insurance coverage, I, as the parent/guardian of the student, may be held responsible for the charges.

Signature of Parent/Guardian_____ **Date**_____

Printed Name of Parent/Guardian_____ **Parent DOB**_____

Staff use only below this line:

Patient Eligibility (circle one): Native American/Alaskan Native Privately Insured T19 T21 *Under*insured Uninsured

Vaccinations Administered (circle all that apply):

DTaP Hepatitis A Hepatitis B HIB HPV Meningitis ACWY Meningitis B MMR PCV Polio TdaP TD Varicella COVID-19 Influenza Pediarix Pentacel Vaxelis Quadracel Proquad

THIS PAGE FOR STAFF USE ONLY

VACCINE/LOT#/EXP DATE	EXT	SITE	ROUTE
	☐ RIGHT ☐ LEFT	☐ DELTOID ☐ VASTUS LATERALIS ☐ UPPER ARM ☐ THIGH	☐ IM ☐ SQ
	☐ RIGHT ☐ LEFT	☐ DELTOID ☐ VASTUS LATERALIS ☐ UPPER ARM ☐ THIGH	☐ IM ☐ SQ
	☐ RIGHT ☐ LEFT	☐ DELTOID ☐ VASTUS LATERALIS ☐ UPPER ARM ☐ THIGH	☐ IM ☐ SQ
	☐ RIGHT ☐ LEFT	☐ DELTOID ☐ VASTUS LATERALIS ☐ UPPER ARM ☐ THIGH	☐ IM ☐ SQ
	☐ RIGHT ☐ LEFT	☐ DELTOID ☐ VASTUS LATERALIS ☐ UPPER ARM ☐ THIGH	☐ IM ☐ SQ
	☐ RIGHT ☐ LEFT	☐ DELTOID ☐ VASTUS LATERALIS ☐ UPPER ARM ☐ THIGH	☐ IM ☐ SQ
	☐ RIGHT ☐ LEFT	☐ DELTOID ☐ VASTUS LATERALIS ☐ UPPER ARM ☐ THIGH	☐ IM ☐ SQ
	☐ RIGHT ☐ LEFT	☐ DELTOID ☐ VASTUS LATERALIS ☐ UPPER ARM ☐ THIGH	☐ IM ☐ SQ

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR:	DATE:	TIME: