Sedgwick County Health Department
VACCINE CONSENT FORM

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

Student Information

Last Name	First Name	Phone	Age	Birth Date
Street Address		City	State	Zip
Gender M___ F___	Hispanic or Latino Yes___ No___	Primary Care Physician:		

Race: ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Native American/Alaska 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 appointment or vaccination reminders for myself or for those for whom I am the parent or guardian. ☐ Phone ☐ Text ☐ Mail ☐ Email (please provide email address)_ _____

Immunization Screening Questionnaire

1. Is the person to be vaccinated currently sick or experiencing a high fever?	☐ Yes	☐ No
2. Has the person had a serious reaction to a vaccine in the past?	☐ Yes	☐ No
3. Does the person to be vaccinated have any allergies that cause a severe (anaphylactic) reaction?	☐ Yes	☐ No
4. Has the person to be vaccinated had a seizure or other neurological problems?	☐ Yes	☐ No
5. Does the person to be vaccinated have any medical problems that make it difficult for him/her to fight infection?	☐ Yes	☐ No
6. Does the person to be vaccinated have close, regular contact with someone who has a weakened immune system?	☐ Yes	☐ No
7. Is the person taking cortisone, prednisone, other steroids, anti-cancer drugs, or had x-ray treatments?	☐ Yes	☐ No
8. Has the person to be vaccinated received blood, plasma, or immune globulin in the past twelve months?	☐ Yes	☐ No
9. Is the person to be vaccinated pregnant or thinking of becoming pregnant within the next three months?	☐ Yes	☐ No
10. What date did you begin your last menstrual cycle? Date:__ _____ _____	☐ Does not Apply	

I give permission for the student above to receive the following vaccinations which he/she has NOT already received. <u>Check the boxes AND initial all that apply</u>.

1. ☐ **Yes**/*Initial:* _ ____ ***All* vaccinations required for school.**
2. ☐ **Yes**/*Initial:* ___ __ ***All* additional vaccinations recommended by the Centers for Disease Control and Prevention/CDC.**
3. ☐ **Yes**/*Initial:* __ ___ ONLY the vaccinations checked below. I understand that my child may be excluded from school due to non-compliance with school vaccination regulations.

School-Required Vaccinations						CDC-Recommended Vaccinations	
☐ DTaP	☐ Td	☐ MMR	☐ Prevnar	☐ Hepatitis A	☐ Meningitis Conjugate	☐ HPV	☐ Meningitis B
☐ Tdap	☐ Hib	☐ Polio	☐ Varicella	☐ Hepatitis B		☐ Influenza	

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

☐ **Yes**/*Initial:* ____I acknowledge that a copy of Sedgwick County's Notice of Privacy Practices dated July 1, 2013, has been made available to me prior to my signing this Consent Form. My signature below gives permission for me/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 vaccination records or 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 student/parent/guardian of the student, may be held responsible for the charges.

Signature of Parent/Guardian or Student_____**Date** _____

Printed name of Parent/Guardian or Student _____**Parent DOB**_____

FOR OFFICE USE ONLY: Patient Eligibility

____T19____No Health Insurance____Native American/Alaska Native____T21____Fully Insured____Underinsured (Insurance does not cover immunizations)

____Underserved (Insurance co-pay or deductible high enough to provide a barrier to immunizations) Yellow – School Located Clinic Consent

Revised 03/2019