

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: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> 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. <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Mail <input type="checkbox"/> Email (please provide email address)				

Immunization Screening Questionnaire

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

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

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
<input type="checkbox"/> DTaP <input type="checkbox"/> Td <input type="checkbox"/> MMR <input type="checkbox"/> Prevnar <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Meningitis Conjugate <input type="checkbox"/> Tdap <input type="checkbox"/> Hib <input type="checkbox"/> Polio <input type="checkbox"/> Varicella <input type="checkbox"/> Hepatitis B	<input type="checkbox"/> HPV <input type="checkbox"/> Meningitis B <input type="checkbox"/> 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	
<input type="checkbox"/> T19 <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> T21 <input type="checkbox"/> Fully Insured <input type="checkbox"/> Underinsured (Insurance does not cover immunizations)	
<input type="checkbox"/> Underserved (Insurance co-pay or deductible high enough to provide a barrier to immunizations)	Yellow – School Located Clinic Consent