## 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**Other | Asian Black/African American | Caucasian | Native American/Alaskan Native | Native Hawaiian/Pacific Islander |
| **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 |
| 1. Has the student had a severe reaction to a vaccine in the past?
 | Yes | No |
| 1. 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: |
| 1. Has the student received any vaccines within the last 4 weeks?
 | Yes | No |
| 1. Has the student, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problems?
 | Yes | No |
| 1. 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 |
| 1. Does the student have an immune system problem such as cancer, leukemia, HIV/AIDS?
 | Yes | No |
| 1. Does the student’s parent or sibling have an immune system problem?
 | Yes | No |
| 1. 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 |
| 1. In the past 12 months, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?
 | Yes | No |
| 1. Is the student pregnant?
 | Yes | No |
| 1. What was the first day of the student’s last menstrual cycle? Date:
 | Not Applicable |
| 1. Has the student ever fainted or experienced dizziness after receiving a vaccine?
 | Yes No | 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

##  Revised 4/2024 English

COVID-19

Influenza

Pediarix

 Pentacel

Vaxelis

Quadracel

Proquad