JCPS JEFFERSON COUNTY PUBLIC SCHOOLS

PATIENT ENCOUNTER/PARENTAL CONSENT FORM FOR SCHOOL IMMUNIZATIONS

PLEASE PRINT

SCHOOL: _____

Child's Last Name:	Child's First Name:	Middle Initial:

Grade:	Age:	Birthdate: (Month) / (Day) /(Year)	Gender: ☐ Male ☐ Female ☐ Other

Address:	City: State	Zip Code:

Phone Number: ( )	Emergency Contact Name & Phone Number: ( )

Parent /Legal Representative:

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Alaska Native ☐ Hawaiian/Pacific Islander ☐ Other:_____

Do you have difficulty reading or speaking English? ☐ YES ☐ NO

What is your primary language? _____

Health Insurance Status:

☐ No Insurance
☐ Medicaid #_____
☐ KCHIP
☐ Private

Health Care Provider:

Does your child have a primary care provider or pediatrician?
☐ Yes ☐ No
Provider name:
_____
Phone number:
(____)_____

JCPS STAFF USE ONLY:

Medical Screening Reviewed _____
KYIR Reviewed _____
Infinite Campus Review _____
Proof of Past Immunizations _____
VFC Eligibility Determined_____
KYIR ID #: _____

Child's Medical Screening (*PLEASE ANSWER ALL QUESTIONS*)

1. Has your child ever had any of the following after a previous vaccine: wheezing, trouble breathing, hives and itching all over the body, swelling in the mouth or throat, very low blood pressure or shock?	☐ Yes ☐ No
2. Has your child ever had a serious reaction after receiving a vaccination (e.g. Guillain Barre Syndrome)?	☐ Yes ☐ No
3. Has your child ever had a serious (life threatening) allergy to latex or to eggs?	☐ Yes ☐ No
4. Has your child received any vaccine(s) within the past 30 days? If yes, list Vaccine(s): Name: Date given:	☐ Yes ☐ No
5. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), a cochlear implant, a spinal fluid leak, or disease of the lungs, heart, kidneys, liver, nerves or blood (including anemia)? Does your child take aspirin or a medication that contains aspirin every day? *Please circle disease(s)*	☐ Yes ☐ No
6. During the past year, has your child received : a blood transfusion, been given immunotherapy (immune globulin), or an antiviral drug?	☐ Yes ☐ No
7. Does your child have a weak immune system? (E.g. treatment for cancer or HIV/AIDS, on medications for rheumatoid arthritis, Crohn's disease, or psoriasis, or taking medications such as steroids may cause the immune system to be weak.)	☐ Yes ☐ No
8. Is your child pregnant or nursing? Please discuss this with your child for verification.	☐ Yes ☐ No
9. Does your child have close contact with a person with a weakened immune system?	☐ Yes ☐ No
10. Does your child have any allergies? (please list)_____ _____	☐ Yes ☐ No
11. Has your child had a previous COVID, Influenza, or MMR vaccine? (list dates)_____	☐ Yes ☐ No
12. Does your child have a fever or is sick today? Has your child been advised to isolate due to COVID-19?	☐ Yes ☐ No

Please Complete & Sign Page 2.

STUDENT NAME: _____ **DOB:** _____

INFORMED CONSENT

I have read or had read to me information about the required childhood vaccines that my child may receive. I have been given the Vaccine information Statement(s) for the vaccines indicated for my child. I had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) to be administered. I also give permission to share my child's immunization record with facilities or institutions, which are required by law to have such records and with their health care provider(s). Of my own free will I consent to the administration of any or all vaccines required for my child's compliance with the Kentucky State immunization requirements. I understand that no guarantees are being made as to the effect of any vaccines or treatments given to my child. I also understand my child may be tested for HIV infection, Hepatitis B, or any other disease carried by blood or body fluids if such a test(s) is needed if a health care worker is exposed to my child's blood, body fluids or tissue. I believe I understand the benefits and risks of any vaccine(s) to be administered. I AUTHORIZE payment of insurance benefits and give consent to release medical information to insurance companies or other agents. By signing this form, the parent/legal representative shall acknowledge that the Jefferson County Board of Education and its employees shall incur no liability and the parent/legal representative shall indemnify and hold harmless the school and its employees against any claims relating to the administration of school vaccines. I authorize the school health clinic to receive and release medical /immunization information about my child to his/her individual school, primary care provider, and immunization registry as needed or requested.

_____ _____ _____

Signature of Parent or Legal Representative | Relationship | Date

OPTIONAL VACCINATIONS: I understand that vaccinations that are not required for school entry may also be available. I have read or had read to me information about the vaccines listed below. I have been given the Vaccine information Statement(s) for the vaccines. I had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) to be administered. I also give permission to share my child's immunization record with facilities or institutions, which are required by law to have such records and with their health care provider(s). If my child is age 15 or under, I understand and acknowledge that the COIVD-19 vaccination has received emergency use authorization from the FDA for usage in populations under the age of 16. I understand and acknowledge that the COVID-19 vaccination has only received full authorization from the FDA for usage in populations aged 16 or older. Of my own free will, **I consent to my child receiving the vaccinations I have indicated below. I understand that those vaccines will only be administered if my child's medical records indicate it is necessary.**

☐ **INFLUENZA** ☐ **COVID -19** ☐ **HPV**

_____ _____ _____

Signature of Parent or Legal Representative | Relationship | Date

CLINIC USE ONLY!!!! VACCINE ADMINISTRATION RECORD

VACCINE	VIS DATE	DATE GIVEN	INJECTION SITE	Dosage	MANUFACTURER	LOT # & EXPIRATION	PROVIDER
			RA LA IM SQ	ml			
			RA LA IM SQ	ml			
			RA LA IM SQ	ml			
			RA LA IM SQ	ml			
			RA LA IM SQ	ml			

Printed Name of Vaccine Administrator_____

Signature of Vaccine Administrator_____

Kentucky Parental Notice for One Time Consent to Allow the School District to Access Kentucky Medicaid Benefits

School District Name: **Jefferson County Public Schools**
School/District Contact: Health Services Office 485-3387

Dear Parent/Guardian:

The purpose of this letter is to ask for your permission to release information needed to recover costs from Medicaid for eligible school-based services. Local education agencies in Kentucky have been approved to receive partial reimbursement from Kentucky's Department for Medicaid Services (DMS) for the costs of certain health-related services provided by the district to your child (or children).

With your permission, the school district will be able to seek partial reimbursement for medically necessary services to Medicaid recipients in accordance with an Individualized Education Program (IEP), an Individual Family Service Plan (IFSP), or are otherwise medically necessary.

The school district will need to share following types of information about your child: name, date of birth; gender; social security number, Individual Education Plan, Service records and any relevant information. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

The school district cannot share information about your child without your permission. When you give permission, please be advised of the following:

1. This will allow the release of information, for the sole purpose of billing Medicaid services or auditing, to the following agencies: DMS, Kentucky Department of Education (KDE), Kentucky Department for Public Health, Centers for Medicare and Medicaid Services (CMS), any agency commissioned to audit this program and contractual third-party billing agents.

2. The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services.

3. This will not affect your child's available lifetime coverage or other Medicaid benefit; nor will it in any way limit your own family's use of benefits outside of school. This will not affect your child's special education services or IEP rights; and it will not lead to any risk of losing eligibility for other Medicaid or DMS funded programs.

4. You have the right to change your mind and withdraw your permission at any time.

I give permission to the school district to share with DMS information concerning my child(ren) and their health-related services, as necessary. I understand that this will help our school seek partial reimbursement of DMS covered services.

Parent/Guardian Signature:_____ Date: _____

Child's Name:	**Date of Birth:**	**Medicaid Number:**

VACCINE INFORMATION SHEETS QR CODES

FLU VIS 01/31/2025	Hib VIS 6/8/21
MMR (SQ) VIS 01/31/2025	Hepatitis A VIS 15/10/21
COVID – Pfizer VIS 01/31/2025	Hepatitis B VIS 12/5/23
COVID – Moderna VIS 01/31/2025	Polio VIS 6/8/21
Varicella (SQ) VIS 01/31/2025	Tdap VIS 6/8/21
DTaP VIS 8/6/21	Td VIS6/8/21
Meningococcal MCV4 VIS 01/31/2025	Men B – Meningitis B VIS 6/8/21
Pneumococcal PCV VIS 05/29/2025	HPV VIS 6/8/21
Pediarix- DTaP, Hepatitis B, and polio (Thru-6YO) VIS 15/10/21	Proquad- (SQ) MMR & Varicella (Thru-12YO) VIS 6/8/21