PATIENT ENCOUNTER/PARENTAL CONSENT FORM FOR Flu/MMR/ COVID VACCINES

PLEASE PRINT

SCHOOL:___________________________________

Child's Last Name:	**Child's First Name:**	**Middle Initial:**
Grade:	**Age:**	**DOB / /**
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**

Health Insurance Status:

☐ No Insurance
☐ Medicaid #__________________
☐ Alaskan Native/American Indian
☐ 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 _________________________

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

1. Has your child had a previous COVID vaccine? If so, please list the dates_________________________	☐ **Yes**	☐ **No**
2. Has your child had a previous Flu vaccine? If so, please list the dates_________________________	☐ **Yes**	☐ **No**
3. Has your child had previous MMR vaccines? If so, please list the dates_________________________ **4.**	☐ **Yes**	☐ **No**
5. Has your child had any vaccines in the last 14 days?	☐ **Yes**	☐ **No**
6. Does your child have a fever today? Is your child sick today? Does your child currently have COVID-19 infection and been advised to be in isolation? **Is your child currently in quarantine for known exposure to COVID-19?**	☐ **Yes**	☐ **No**
7. Have you ever had a severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component, or injectable therapy? Symptoms of a reaction include: difficulty breathing, swelling of your face and throat, fas heartbeat, bad rash all over your body, dizziness, weakness.	☐ **Yes**	☐ **No**
8. Is your child currently pregnant or a chance they may be pregnant?	☐ **Yes**	☐ **No**
9. Is your child immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, smoke, or have diabetes mellitus? Is your child receiving any immunosuppressive therapy?	☐ **Yes**	☐ **No**

Please Complete & Sign Page 2.

10. **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 imm system to be weak.)**	☐ **Yes** ☐ **No**
11. **Has your child received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment?**	☐ **Yes** ☐ **No**
12. **Does your child have close contact with a person with a weakened immune system?**	☐ **Yes** ☐ **No**
13. **Does your child have any allergies? (please list)**____ ____	☐ **Yes** ☐ **No**

INFORMED CONSENT

I have read or had read to me information about the Flu/ MMR &/or COVID vaccine(s). I have been given the Vaccine information Statement for the Flu/MMR &/or COVID vaccines(s). I had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine to be administered. If my child is age 15 or under, I understand and acknowledge that the COVID-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 the administration of the Flu/MMR &/or COVID vaccines(s) to my child. I understand that no guarantees are being made as to the effect of any vaccines or treatments given to my child. I understand that the vaccines may be administered to my child by JCPS employees or other trained volunteers authorized by the district. 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 AUTHORIZE payment of insurance benefits and give consent to release medical information to insurance companies or other agents. By signing this form, I acknowledge that the Jefferson County Board of Education and its employees shall incur no liability and I 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 to my child's primary care provider, and to my insurance carrier as needed. I understand that information about this COVID vaccination will be included in the Kentucky Immunization Registry (KYIR).

Please check each vaccine consent is given to administer:

Flu [ ]   MMR[ ]   COVID[ ]

____   ___________________________   ___________

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**
Flu			**RA LA IM**	ml			
MMR			**RA LA SQ**	ml			
COVID-19			**RA LA IM**	ml			

Printed Name of Vaccine Administrator____

Signature of Vaccine Administrator____

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Please Complete & Sign Page 2.