HarveyCounty

Public Health
Prevent. Promote. Protect.

Investing today for a healthy tomorrow

HEALTH DEPARTMENT
PINE STREET HEALTH SERVICES
215 S. PINE STREET, 2ND FLOOR
NEWTON, KANSAS 67114

PHONE: 316-283-1637
FAX: 316-283-1757

March 7, 2017

Dear parents of preteens and teens:

There are four vaccines recommended for preteens and teens—these vaccines help protect your children, your family members and friends. While your kids should get a flu vaccine every year, the three other preteen vaccines should be given when kids are 11- 12 year of age.

The following vaccines are recommended by the American Academy of Pediatrics (AAP), the American Council of Immunization Practice (ACIP), and the CDC:

- ✓ ***Tdap*** - Tdap vaccine protects against tetanus, diphtheria and pertussis (whooping cough).
- ✓ ***Meningococcal*** - Meningococcal conjugate vaccine protects against some of the bacteria that can cause meningococcal disease including sepsis and meningitis.
- ✓ ***HPV*** - Human papillomavirus (HPV) vaccines help protect both girls and boys from HPV infection and cancers caused by HPV.
- ✓ ***Flu*** - 6 months of age and older should get a flu vaccine every year.

The Harvey County Health Department will be offering three of the vaccines **at Santa Fe 5/6 Center on Friday, April 28th and Friday, May 5th.** Our goal is to insure students and staff are up to date on all vaccines. Vaccines offered include:

- Tdap (Tetanus, Diphtheria and Pertussis)
- HPV (Human Papillomavirus Virus)
- Meningitis

Attached you will find the SLV Registration Form. If you would like to have your child vaccinated, please complete the Registration Form and return it with payment to your child's school or the Health Department by **Thursday, April 20th.**

We accept private insurance, Medicaid and KanCare. A copy of both sides of the insurance card must be sent with the Registration Form. A sliding fee scale is available for those who qualify. See the Registration Form for more information. We will be unable to vaccinate anyone with incomplete paperwork or payment.

A copy of the Harvey County Health Department's Notice of Privacy Practices and Vaccine Information Sheet will be sent to you upon request. Both of these sheets will be available to students the date of the vaccination and can be found on our website and at http://www.cdc.gov/vaccines/hcp/vis/current-vis.html.

Please contact the Harvey County Health Department with any questions.

Sincerely,

Tobias Harkins
Assistant Director/Director of Nursing

HARVEY COUNTY HEALTH DEPARTMENT REGISTRATION FORM

Circle vaccine(s) to be given to client named below. **Tdap** **HPV** **Meningitis**

CLIENT INFORMATION: Last: _____ First: _____ MI: _____

Birth Date: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: H (___)_____ Cell (___)_____ Work (___)_____

School: _____ E-Mail, if over age 18: _____

==========

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Widowed

Race: ☐White ☐ Asian ☐Black/African Am. ☐Am. Indian ☐Native Hawaiian/Pacific Islander ☐ Other

Ethnicity: ☐Hispanic ☐Non-Hispanic

==========

PARENT/GUARDIAN INFORMATION (if client is under 18):

Last: _____ First: _____ MI: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: H (___)_____ Cell (___)_____ Work (___)_____

SS#_____ E-Mail: _____

==========

For clients age 18 years and under only: Check one below.

☐Private insurance ☐KanCare ☐Medicaid ☐No insurance ☐Insurance does not cover immunizations

☐Children are school age **and** enrolled in Free or Reduced Lunch Program (proof must be provided).

==========

Payment or arrangements must be made before the vaccination will be given. How do you plan to pay?

☐ I will pay full fee today. Cash or check. Make check out to the Harvey Co Health Dept.

☐ I wish to apply for a reduced fee. My family's **gross** income is _____ per _____. (Please use your most current IRS Form 1040 Adjusted Gross Income if you filed taxes.) Number in household: _____.

☐ Bill private health insurance plan. Insurance card must be presented at time of service.
Policyholder's Name: _____ Policyholder's DOB: _____

☐ Bill Medicare. Card must be presented at time of service.

☐ Bill Healthwave and/or Medicaid. Insurance card must be presented at time of service.

==========

Please read and check each box that applies before signing.

☐ I request the vaccines that have been circled be given to the person named above for whom I am authorized to make this request.

☐ I authorize immunizations for the person named above be sent to his/her school upon request.

☐ I request a copy of the Vaccination Information Statement(s) marked above be sent to me.

☐ I request a copy of Health Department's Notice of Privacy Practices with the effective date of September, 12 2013 be sent to me.

☐ I request payment of insurance benefits to the Harvey County Health Dept.

☐ I authorize the release of only the medical or billing information necessary to process claims for insurance providers including Medicare or Medicaid.

☐ I agree to be fully responsible for any co-pay, deductible or non-covered services.

_____ _____ _____

Signature of Client or Responsible Party Relationship to Client Date

For the client to receive any vaccine, all questions on the back must be answered.

Does the client have any known allergies medicine?	NO	YES
Please list: _____		
Does the client have any known allergies to eggs, egg protein, or gentamicin?	NO	YES
Other food allergy? Please list: _____		
Has the person to be vaccinated had any vaccinations (shots) before?	NO	YES
Has the client received any vaccine within 30 days before today?	NO	YES
Has the client ever received an influenza vaccine?	NO	YES
Has the client ever had a reaction to an influenza vaccination?	NO	YES
Has the client ever had Guillian-Barre syndrome (a form of paralysis)?	NO	YES
Does the client have an allergy to latex?	NO	YES
Does the client have asthma, recurrent wheezing (if under 5), active wheezing?	NO	YES
Is the client receiving aspirin or aspirin-containing treatment (if under 18)?	NO	YES
Is the person to be vaccinated currently sick or experiencing a high fever?	NO	YES
Does the client have any of the following:		
kidney disease?	NO	YES
heart disease?	NO	YES
blood disorder?	NO	YES
metabolic diseases (e.g. diabetes)?	NO	YES
Any disease that lowers the body's resistance to infection?	NO	YES
Is the client taking steroids, arthritis medication, chemotherapy or recently completed a course of steroids?	NO	YES
Has the person to be vaccinated had a seizure, convulsions or other neurological problem?	NO	YES
Will the client have close contact with anyone who has a weakened immune system and requires care in a protective environment?	NO	YES
Is the client pregnant. nursing, or thinking of becoming pregnant within the next three months?	NO	YES
If not pregnant, what was the date of the most recent menstrual period?_____		

==========

FOR CLINIC USE ONLY

VACCINE	EXT	SITE	ROUTE	VIS DATE	DOSE	MANUFACTURER, LOT #, EXP DATE
Tdap	RT LT	Deltoid Vastus Lat	IM	04/15/15		
HPV	RT LT	Deltoid Vastus Lat	IM	02/24/15		
MCV4	RT LT	Deltoid Vastus Lat	IM	03/31/16		

09/30/2015

_____ _____

Signature and Title of Vaccine Administrator Date