Waco ISD Immunization Day at the McLennan County Public Health District

November 16, 2020

Parents/Guardians:

Waco ISD will be transporting students to the McLennan County Public Health District on Wednesday, December 2, 2020 to receive state required immunizations. If you are receiving this letter, it is because your student is delinquent on one or more immunizations that are required to attend public school. If your student is up to date on immunizations, please provide your campus nurse with a current shot record before November 20, 2020 (by November 30 if your child's campus is currently closed for in-person instruction).

If you would like your student to participate in this event, please fill out the attached permission forms and return them by November 30, 2020. Students will be transported by bus to the health district to receive immunizations and back to campus during the school day. If your student is 5th grade or below, a parent/guardian must be present for your student to receive immunizations. You may bring your student to the health district or meet the bus there.

The McLennan County Public Health District accepts the following insurance providers; Medicaid, Aetna, Humana, Blue Cross Blue Shield, FirstCare and Cigna. Please provide a copy of your student's insurance/Medicaid card with the completed permission forms. Students without the insurance providers listed above, will be asked for a $14 administration fee.

You may also take your student to their primary care provider to receive their state required immunizations. If your student does not have a PCP, please see the attached flyer for Family Health Center's Women and Children's Hotline.

All students enrolled in public school must be up to date on immunizations or must have a current form of conscious exemption on file by Friday, December 4, 2020.

If you would like to discuss your child's immunization records, please contact your campus nurse directly. Online forms can be found on the WISD Student Health Services website.

Thank you,

Rhiannon Settles, BSN, RN-BC
Director of Health Services
254-754-9480

•. . Please fill in shaded areas
. . •Por favor llene las areas acentuadas

OSS
D I
OFV

O **No Shot Record**

Immunization Form

Waco-Mclennan County Public Health District
225 W. Waco Drive
Waco, TX 76707

bate of Service 12-02-2020

First Name I Primer Nombre	Middle Initial/ Nombre Segundo:	last Name / ApeJlido

Sell/Sexo (check one) (marc:aunol
oMale Hombre
oFemale Mujer

Date of Birth
Fecha de Nacimiento
__ / __ / __
MM DD VY
•• Dia Aφo

Address/Direcclon: _____

City/Cludad: _____ County/Condado _____ Zip _____

Telephone #/Numero de telefono: _____

liousehold Receives W.t.C: Redbe w.r.c. en sucasa:
□ Yes/Si
ɑ No/No

Medicaid Number/Numero de Medicaid	$S NUMBER/ Numero de Segura Social	Mother's Malden Name/Apellldo de Soltera de la Madre

o Remind Me: I consent to vaccine reminders by email _____
c Dov permiso a notlfIcadones nor coneo electronlco _____

OFFICE USE ONLY

Circle Series of Immunization	Manufacturer/ VIS Date	NOC Code	Vaccine Procedure Code	Lot#	Site
1 2 3 Pedlarbc (DTaP/IPV/Hep B)	GSK		90723-223		
1 2 3 4 Pentacel (OTaP/HIB/IPV)	SNF		90698-223		
4 KinriK (DTaP/IPV)	GSK /SNF		~~90696-223~~		
1 2 3 4 OTaP {aceUular)	GSI</SNF		90700-223		
OT	SNF		90702		
1 2 3 4 Td	M.810/SNF		90714-Z23		
1 TdaP	GSK/SNF		90715-223		
1 2 3 4 IPV	SNF		90713-223		
1 2 3 4 HIBcv	GSK/SNF		90648-223		
1 2 HEPA(PediJ	GSK		90633-223		
1 2 HEPA(Adult)	GSK		90632-223		
1 2 3 HEPB(Pedl)	GSK/MRK		90744-223		
1 2 3 HEPB(Adult)	GSK/MRK		90'746-223		
1 2 3 4 HEP B/HEP A (TwinRI)	GSK		90636-223		
1 2 MMR MMRV	MRK		MMR 90707•Z23 / MMRV 907111-Z23		
1 2 Meningococc.il	GSK/SNF		90734-223		
1 2 3 HPV9	MRK		90651-223		
1 2 3 ROTATEQ	MRK		90680-223		
1 2 Inffuenza (6-35 mol Quad, PfS			MO<llca;d 907 9 / 90710-Z23		
1 2 Influenza 6 mo+, Quad, MOV			90688-223		
1 2 Influenza 6 mo , Quad, PFS			90686W		
1 2 Influenza, Nasal, 2·49 vr	Medimmune		90672-223		
1 Pneum. Poly- 23	MRK		90732-223		
1 2 3 4 Pneumococ I Conjugate-13	Phizer		90670-Z23		
1 2 Varlcella	MRK		90716-Z23		
1 2 Mentngococcal B	GSK/Phlzer		90620.m I 90621-Z23		
1 Typhoid	SNF		90691-Z23		
1 Yellow Fever	SNF		90717-Z23		
1 2 Shingrix	GSK		90750		
TB Skin Test Gtven Yes No	SNF		86S80		

legend: Merk= MRK GlaxoSmithKline=GSK Sanofi = SNF

•••Please fill in shaded areas
u • Por favor llene las areas acenluadas

The client or the dlent's parental guardian must answer ALL of the following questions before anv Immunizations wlll be given.
El cliente o el custodio legal tlene que contestar TODAS las siguientes preguntas antes de recibir lnmunizaciones.

(Circle Answer/ Circule las respuestas)

YES/ SI NO 1. Is the dient sick today or has he/she been sick In the last week?
Esta el cliente enfermo hoy o el/el/a a estado enfermo/a en lo ultimo semano?

YES/ SI NO 2. Is the client taking any medications? If so, please 11st them here: _____
El cliente toma olguna medicina? Si responde st porfavor listo oqul: _____

YES/ Sf NO 3. Does the client have allergies to gelatin/Jello, neomycin, streptomycin, polymyxin 8, baker's yeast, eggs, thlmerosol, latex, or reaction *to* Immune Globulin?
Tiene el cliente alergios a la gelatina, huevos, neomicino, estrotomicina, po/ymyxin B, thimerosol, productos que contienen levadura de ponadero, productos de latex o reocclon a Globulin Immune?

YES/ SI NO 4. Has the client had a serious reaction to a vaccine in the past?
El cliente o tenido alguna reoccion grave a uno vocuno en el pasado?

YES/ SI NO S. Has the client had a seizure or other nervous system disorders?
El cliente a ten/do convulsiones o otros ataques defsistema nervioso.

YES/ SI NO 6. Does the client (or other persons In the home) have cancer, leukemia, AIDS or any other immune system problem?
El c/iente o persanos que viven en el mismo hogor, tienen SIDA, cancer, leukemia o en/ermedades que debilitan el sistema inmunologico.

YES/ SI NO 7. Has the client taken cortisone or other steroids, anticancer drugs, or x-ray treatments In the past 3 months?
El c/lente a tornado cortisone or otro tipo de esteroides, drogas anticancer, o tratamientos de radiogro/ia en los posados 3 meses?

YES/SJ NO 8. Has the client received a blood transfusfon, plasma, or been given a medicine called Immune (gamma) globulin in the past 12 months?
El cliente o recibido una transfusion de sangre, plasma, ofue dodo uno medicina llomodo globln lnmune (gamma) en /os pasados 12 meses?

YES/SI NO 9. Has the client had the chickenpox Illness? Or has received the vaccine?
El cliente a tenldo lo enfermedad de Viruela o a reclbldo la voccuna contra la Varice/a?

YES/ SI NO 10. Has the client had a TB skin test in the past 3 days?
El cliente a recibido uno prueba de piel de TB en los posados tres dias?

YES/ SI NO 11. FOR TB SKIN TES: Has the client had a positive TB test In the pa5t or taken TB medications? If so, when?
_____
Pruebo de tuberculosis: El cliente o reclbldo uno pruebo posltivo de tuberculosis en el posodo o a tornado medicina poro trotar el tuberculosis? Cuando?_____

Y£S/SI NO 12. Has the dlent had an Immunization In the past 4 weeks?
El cliente a recibido vaccunas en los pasodos cuatro semanas?

YES/ SI NO 13. Does the client have a family physician? If "NO" see provfder list.
Tlene el cliente un doctorfamiliar? En coso que "NO" porfavor veo la listo de proveedores.

YES/SI NO 14. Does the client have a chronic medical condition (regardless of age). Such as:
Asthmc1 or another lung disease? YES/NO Heart disease? YES/NO Diabetes? YES/NO
Kidney disease YES/NO Blood disease? YES/NO Are you pregnant? YES/NO
Weakened immune system? YES/NO
Have you been vaccinated with Pneumonia Vaccine YES/NO
O£1c/iente tiene alguno condicion medico cronica (sin importor lo edod). Toi como:
Asma o olguna otra en/ermedad pulmonary? SI/NO Enfermedod de/ Corazon? SI/NO
En/ermedod de los rinones? SI/NO En/ermedod de lo sangre? SI/NO Esta embarazado? SI/NO
Deficiencias de/ sistema immunologlco? SI/NO A recibido la vaccuna contra la neumonia? SI/NO

YES/ St NO 15. FOR FEMALES: Is the client pregnant or could she become pregnant In the next (1) month?
UNote: A client must NOT become pregnant within 1 month after receiving the MMR (measles, mumps, rubella) vaccine or the Varlcella (Chickenpox) vaccine.
SI el cliente es una mujer - El cliente esta embarazada o podria /legar a ser embarazada en un (1) mes?
ONoto: Un cliente no debe llegar a serembarozado dentro de un (1) mes despues de recibir la vacuno de MMR (Sarampian,, Paperas, Rebeolo) ni la vacuna de Varlcela.

• The client or the cleints parent/guardian must answer A l l questions on this form before any Immunizations wlll be given.
**El cliente o el padre/madre del cllente o c11stodio legal tiene q11e contestar TODAS las preguntas que estan en esta forma antes de reciblr lmmunizaciones.
CONSENT FOR IMMUNIIATIONS: Ihave received, read or had explained to me the vaccine Information statement and Iundentand this Information. tgive permission to the Waco-Mclennan County Public: Health District, lts staff and other health care pel'50nnel under IU sponsorship, to give Immunizations and/or TB tkln tst to the person Identified on this form. Iundertand that Immunizations siven at school sites may be given without me beins present.
CONSENTIMIENTO PARA INMUNIZACIONES: E recibido, leido/o e><plicado la informacion v si entiendo esta informacion. Le dov permiso al personal de esta institution para que se le admlnlstren vacunas o la prueba de Tuben:ulosls a la persona nombrada en est;i forma. Entiendo que las vacu11c1s administradas en la escuala se podran dar sin que yo este presente.

Signature of CONSENTING ADULT/ Firma del adulto que da permlso: _____ Date Signed/Fecha de Firma: -"/12/02/2020...

{Check one/marc:a uno) D Parent/ padre/madre D Guardian/El suardian ☐ Other/Otro

VIS Form/s given & vaccine ADMINISTERED BY: Date Signed 12-02

-TEXAS
Healtfl and Human semces | Tew Department of State Heaftll Services

Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visfr to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiYing vaccines under the TilFC Program.

1. Child's Name: ---------- (Last Name, First Name, MI)
2. Child's Date of Birth: ----/---/---- (MM DD YYYY)
3. Parent, Guardian, or Individual of Record: _____ (Last Name, First Name, MI)
4. Primary Provider's Name: ---------- (Last Name, First Name, MI)
5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC Program, at each immunization encounter or visit, enter the date and mark the appropriate eligibility category. If Column A - F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for federal VFC vaccine.

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	* Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines
12/02/2020							

** Underinsund includes children with health insurance that does not include vaccines or on/Ji covers specific vaccine !Jpes. Children are onjy engible 0r vaccines that are. not covered in111ranct. In addition, to receive VFC vaccine, underinsured children must be Jiaccinated through a Federal/)' 2ualified Health Center (FQHQ, a Rural Health Clinic (RHC), or under an approved deputizedprovider. The deputizedprovider must have zutritten agreement utith an FQHC or an RHC and the state, local or temtorial immunization program in order to vaccinate underinsured hildren.*

*'** Other 1mderins11redare children that are underinsured but are not eligible to receive federal vaccine through the TVFC Program because the 1rovuler orfacility is not an FQHC or an RHC, or a deputizedprovide,: However, these chtldren mt!J be served if vaccines areprovided the fateprogram to cover these non-Tv'FC-eligible children.*

*'** Childnm enrolled in the State of Texa.t Children's Health lns11rance Program (CHIP). An agreement between the DSHS Immunization*

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent.to the use or disclosure of my protected health infonnation by the Waco-McLennan County PubHc Health District for the purpose of diagnosing or providing treatment to me, obtaining payment for y health care bills or to conduct health care operations of the Waco-McLennan County Public Health District.

I understand that diagnosis or treatment of me by the Waco-McLennan County Public Health District may be conditioned upon my consent as evidenced by my signature on this document.

J understand that I have the right to request a restriction as to how my protected health information is used or disclosed to cany out treatment, payment or health care operations of the practice. The Waco-McLennan County Public Health District is not required to agree with the restrictions that I may request. However, if the Waco-McLennan County Public Health District agrees to a restriction that I request, the restriction is binding on the Waco-McLennan County Public Health District.

l have the right to revoke this consent, in writing, at any time, except to the extent that the Waco-McLennan County Public Health District has taken action in reliance on this consent.

My "protected health information" means health infonnation, including my demographic infonnation, collected from me and created or received by the Waco-McLennan County Public Health District staff, another health care provider or a health plan. This protected health infonnation relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the infonnation may identify me.

I understand I have the right to review the Waco-McLennan County Public Health District's Notice of Privacy Practices prior to signing this document.

I have received a copy *of* the Waco-McLennan C ninty Public Health District's otice of Privacy Practjces.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bilJs or in the performance of health care operations of the Waco-McLennan County Public Health District.

The Notice of Privacy Practices for the Waco-McLennan County Public Health District is also posted in each department of the Health District and on the City of Waco's web site at www.waco-texas.com /services/health.

This Notice of Privacy Practices also describes my rights and the duties of the Waco-McLeMan County Public Health District with respect to my protected health information.

The Waco-McLennan County Public Health District reserves the right to change the privacy practices that are described in the Notice of Privacy Pntctices.

/ may obtain a revised Notice of Privacy Practices by accessing the Waco-McLennan County Public Health District's web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next visit.

Signature of Client or Authorized Representative

Relationship

12-02-20

Name of Client

Date **Of Birth**

Date

STUDENT ACTIVITIES:
TRAVEL

ACKNOWLEDGEMENT OF RESPONSIBILITY AND PERMISSION FOR STUDENT PARTICIPATION IN SCHOOL-SPONSORED TRIP

Dear Parent/Guardian:

Our_____ will visit_____
NAME OF CLASS OR ORGANIZATION DESTINATION

in_____ . Transportation will be by_____ .
LOCATION

The expense for your child will be _____ for _____.
Please sign the form below consenting for your child to participate.

_____
Sponsor's Signature

I, _____ (parent), agree to allow my child,

_____ (child's name), to travel with a group or individual associated with the District, and agree to assume any and all liability and hold the District, its Trustees, employees, and agents harmless from all claims or actions which I or my child ever had, now have, or may have in the future or any liability for injuries or damages which occur to my child or to me as a result of his or her participation in this trip.

I expressly waive all claims for medical expenses, loss of services, or other claims, and I agree to indemnify and hold harmless the District, its Trustees, employees, and agents from all claims made against it or them on behalf of my child.

I agree to indemnify and hold harmless the District, its Trustees, employees, and agents from all claims made by third parties against it or them which result from my child's actions on the trip.

I understand that the District, its Trustees, employees, and agents are not waving any sovereign governmental immunity which it or they have under Texas law.

I have read and understood this release and sign it voluntarily and with full knowledge of its significance. This release applies to the trip described above.

_____ _____
Parent or Guardian Date

[NOTE: The sponsors of any student trip should take with them copies of each student's Authorization to Secure Emergency Medical Treatment.

(**This form is for use with local travel only.**)

To Be Filled Out by Parent

WACO INDEPENDENT SCHOOL DISTRICT
Emergency Medical Release Form

Date_____

Authorization to Consent Medical Treatment of a Minor

In case of an emergency and I (parent/guardian) cannot be reached, please contact:

_____ _____
Contact Person Telephone Number

_____ _____
Contact Person Telephone Number

_____ _____
Child's Physician Telephone Number

If your child has an existing health condition, please indicate:
Heart trouble _____ Allergies_____ Epilepsy_____
Asthma _____ Diabetes_____ Other_____

Is your son/daughter allergic to any medication? Yes_____ No_____
If yes, please list:_____

Insurance Information

_____ _____
Name of Insurance Company Policy Number

_____
Name of Policy Holder

Consent

The Waco Independent School District is an educational institution in which the child named above is enrolled, and I give authority to Waco Independent School District to consent to medical treatment of the child in the event that I cannot be contacted.

I have read, understand, and agree to abide by the Student Conduct Rules and Regulations stated on the reverse side of this form.

_____ _____
Parent's/Guardian's Signature Student's Signature

_____ _____
Telephone Number Date