USD 247 SOUTHEAST LANCERS

October 2018

Dear Parents/Guardian:

Flu Season is nearly here. Again this fall, Community Health Center will be providing flu vaccinations at school. The flu vaccine will be available to all students Pre-K-12 with parental permission only. If you would like your child to receive the seasonal influenza vaccination in school, please follow the steps below.

Step 1 Consent (please complete and return prior to clinic date)

- The Outreach Consent Form must be completed in ink and signed by a parent or legal guardian.
- The Influenza Informed Consent Form must be completed in ink and signed by a parent or legal guardian.
- Forms need to be completed and returned to the school prior to the scheduled clinic
- Your child will not be vaccinated if we do not receive a completed forms.

Step 2 Payment

- CHC/SEK will bill your child's insurance, if applicable, but no out of pocket cost.

Flu Vaccination Clinic – October 17th

If you have additional questions about flu vaccination, we encourage you to contact me 620-404-8147.

Sincerely,

Lacey Wilbert, RN
USD 247 School Nurse

Community Health Center of Southeast Kansas

Thank you for choosing Community Health Center of Southeast Kansas, Inc. (CHC/SEK) for your healthcare needs. Please note that all information provided by you will be kept strictly confidential in compliance with Federal privacy laws. If you have any questions or need assistance, please ask the receptionist or call 620-231-9873. *Please complete this form in ink.*

PATIENT INFORMATION

Full Legal Name (Print)

Last Name:	First Name:	Middle Name:

Mailing Address_____ City _____

State_____ Zip Code_____ E-Mail Address_____

Do you want to access your medical records electronically? ❑Yes ❑No
(If yes, you will receive an email, at the email address listed above, from CHC/SEK with your log-in information and the log-in URL.)

Home Number_____ Cell Phone_____ Work Phone_____

Preferred method of communication for appointment reminders: ❑ Text ❑ Phone Call

Date of Birth_____ Male❑ Female ❑ Social Security Number_____

Marital Status:	**Employment Status:**	**Student Status:**
❑Divorced	❑Active Duty Military	❑Full-time Student
❑Married	❑Full-time Employment	❑Part-time Student
❑Partner	❑Part-time Employment	❑Not in School
❑Single	❑Self-Employed	
❑Widowed	❑Retired	
❑Legally Separated	❑Unemployed	

RESPONSIBLE CAREGIVER (Children under 18 years of age OR Adults with Durable Power of Attorney)
(Children under 18 years of age, please list two Responsible Caregivers)

Name:_____	Name:_____
Date of Birth: _____	Date of Birth: _____
Social Security Number: _____	Social Security Number: _____
Relationship to the Patient:_____	Relationship to the Patient:_____
Mailing Address: _____	Mailing Address: _____
City, State, Zip: _____	City, State, Zip: _____

(If Responsible Caregiver(s) is a foster parent or out-of-home placement, immediately produce appropriate paperwork illustrating placement and appropriate paperwork illustrating who maintains authority to make medical decisions on the patient's behalf).

Please Complete the Back of Form

EMERGENCY CONTACT

In the event of an emergency, who should we contact? _____
Relationship?_____
Home Number _____ Cell Phone_____ Work Phone _____

INSURANCE INFORMATION

Check all that apply:

❑No Health Insurance (Patient navigators are available to help determine if you are eligible for medical discounts or coverage)

❑KanCare (Amerigroup, Sunflower, United HealthCare) ❑Commercial Insurance
❑Other Medicaid ❑Medicare ❑Medicare Supplement
❑Motor Vehicle Accident ❑Workers Compensation ❑Other Accident

Provide insurance information below. Please provide the front desk with your insurance card for billing purposes.

Primary Insurance	**Secondary Insurance**
Insurance Plan_____	Insurance Plan_____
Member ID Number _____	Member ID Number _____
Group Number _____	Group Number _____
Policy Holder Information:	**Policy Holder Information:**
Full Name _____	Full Name _____
Date of Birth _____	Date of Birth _____
Social Security Number _____	Social Security Number _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____

FINANCIAL INFORMATION (Please fill-out to help determine if you are eligible for medical discounts)

Persons In Family/Household: ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑Other_____
Estimated Annual Family/Household Income:_____

Race:
❑American Indian/Alaskan
❑Asian
❑Native Hawaiian
❑Black or African American
❑White
❑Hispanic
❑Other Race
❑Pacific Islander

Ethnicity:
❑Hispanic/Latino
❑Not Hispanic/Latino

Preferred Language:
❑English
❑Spanish
❑Other _____

Veteran
❑Yes
❑No

If you are Homeless, are you:
❑On the Street
❑Doubling Up
❑In Transitional Housing
❑In a Shelter
❑Other

Have you or has anyone in your household worked in agriculture, such as planting, cultivating, or harvesting (fruits, vegetables, grains, or dairy) in the last two (2) years as a:

❑Not Applicable ❑Seasonal Worker ❑Migrant Worker

Pharmacy:_____ _____
Name City & State

**Apothecare, physically located inside CHC/SEK's Pittsburg and Iola clinics, is CHCSEK's preferred pharmacy.

CHC SEK **Community Health Center of Southeast Kansas**
Pittsburg Baxter Springs Columbus Parsons Iola Coffeyville Independence

Influenza Vaccine Informed Consent

Patient's Full Name: _____ Age:____

Date of Birth: _____/ _____/ _____ Male (M) or Female (F): ___ Phone: _____

Street Address: _____ City: _____ Zip: _____

Please answer the following questions:

Questions		**Yes/ no**
1.	Are you a patient of CHC/SEK?	Y / N
2.	Have you had the flu shot or flu-mist before?	Y / N
3.	Have you ever had an allergic reaction to the flu shot?	Y / N
4.	Do you currently have a fever or illness?	Y / N
5.	Are you allergic to eggs, chicken, or chicken feathers?	Y / N
6.	Are you allergic to thimerosal or mercury?	Y / N
7.	Have you had a condition called Guillain-Barre Syndrome?	Y / N
8.	Do you have asthma or COPD?	Y / N
9.	Do you or any household members have a problem with your immune system?	Y / N
10.	Have you taken steroids(prednisone,orapred,medrol-dose pack) in the last 2 weeks?	Y / N
11.	Are you pregnant?	Y / N

FOR PATIENTS AGE 18 and UNDER -- Indicate VFC Eligibility						
___Medicaid/VFC		___Native Am/ Alaskan Native	__Underinsured*^	___Underserved**^	___No Health Insurance	___Fully Insured

*Underinsured children: insurance does not cover immunizations, are eligible through VFC program if vaccinated at a FQHC or RHC.
**Underserved children: children have insurance co-pay or deductible high enough to provide a barrier to immunizations.
^ Underserved and Underinsured children are eligible through state funded vaccine program if vaccinated at a public county health clinic.

I have been offered a copy of the Vaccine Information Statement (VIS). I have read, had explained to me, and understand the information in the VIS. I ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. If a minor, I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above.

A copy of the notice of Privacy Practices has been made available to me.

_____ _____
Signature of Patient or Parent/Guardian Date

Updated 08/29/2017

What to do for "yes" answers:

1. document in patient electronic medical record
2. if no, and less than 9 years old, will need 2nd immunization after 30 days
3. if yes, no flu shot or mist
4. if yes, no immunization, return for immunization when well
5. if yes, advise patient of the increased risk of allergic reaction. If patient elects to receive vaccine, watch for 15 minutes after administering immunization for reaction.
6. if yes, may use flu-mist or single dose infant. NOT fluzone multi-dose
7. no flu shot or mist
8. if yes, give flu shot, NOT flu-mist
9. if yes, give inactivated flu shot, NOT flu-mist
10. if yes, no immunization today, return 2 weeks after steroids completed
    (for patients chronically on steroids (>2weeks), give inactivated flu shot today)
11. if yes, only give inactivated flu shot, NOT flu-mist. Can be given anytime during pregnancy

Influenza vaccine dosage, by age group

Age	Dose	No. of Doses
6months-8 years	0.5mL	2*
9 years through Adults	0.5 mL	1

*Two doses are recommended for children under 9 years of age who have not been previously vaccinated with influenza vaccine. The two doses should be administered at least one month apart and if possible, the second dose should be given before December

Lot #: Manufacturer: Exp: NDC:

VIS DATE: 08/07/2015

___ 0.5 ml administered to the LEFT / RIGHT deltoid/ anterolateral

_____Date_____
Signature & Title of Vaccine Administrator

Outreach Consent Form

Community Health Center of Southeast Kansas, Inc. (CHC/SEK) will be providing outreach services at your child's school this year. All children are invited to participate in CHC/SEK's outreach program. No child will be denied services based on insurance status or ability to pay. However, insurance, if available, will be billed. Please note that all information provided by you will be kept strictly confidential in compliance with Federal privacy laws. If you have any questions or need assistance, please call **620-240-5061**. *Please complete this form in ink.*

School Name: _____

Student Name: _____**DOB**:_____**Grade**:_____ **Gender**: _____

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race

Ethnicity (circle one): Hispanic or Latino -OR- Not Hispanic or Latino

Do you want access to your medical records electronically? (circle one) YES OR NO

IF yes, Email Address: _____
(If yes, you will receive an email, at the email address listed above, from CHC/SEK with your log-in information and the log-in URL)

Does the child have medical insurance? (circle one) YES OR NO

If YES, complete the insurance section below. CHC/SEK will bill your insurance for services provided.

- ☐ KanCare (Amerigroup, United Health Care, Sunflower) #_____
- ☐ Medicaid (Oklahoma or Missouri)#_____
- ☐ Commercial/ Private Insurance

Subscriber Name_____DOB_____SSN#_____

Insurance Company_____Policy#_____Group#_____

Parent/Guardian Name_____ Daytime Phone #_____

Address_____City_____State_____Zip_____

Consent: As parent or legal guardian of the patient named above, I give CHC/SEK permission to provide my child with the following service(s): **Flu Shot.**

This consent is valid for one year from the Parent/ Guardian Signature date below.

Parent/Guardian Signature_____ Date_____

Medical History Form

Student Name: _____ DOB_____

Medical History: Please check all that apply

Heart Condition:	❑ Heart Murmur	❑ Congenital Heart Disorder	❑ Other: _____
Lung Condition:	❑ Asthma	❑ Cystic Fibrosis	❑ Other: _____
Endocrine Condition:	❑ Diabetes	❑ Thyroid Disorder	❑ Other: _____
Neurologic Condition:	❑ Seizure Disorder	❑ Concussion	❑ Other: _____
Bone/Joint Condition:	❑ Pins/Screws	❑ Rheumatoid Arthritis	❑ Other: _____
Infectious Condition:	❑ Hepatitis	❑ HIV	❑ Other: _____
Behavioral Health:	❑ Anxiety	❑ Depression	❑ Autism Spectrum
	❑ Other: _____		
Severe Allergy to:	❑ Peanuts	❑ Bee/wasp stings	❑ Other: _____
	Reaction: _____		

Other Condition(s): _____

Does your child have special health care needs? (circle one) YES OR NO

IF yes, please explain:

_____

_____

Surgeries/ Hospitalizations? (circle one) YES OR NO

IF yes, please explain:

_____

_____

Please list any known allergies (medications, foods, etc.):

_____

Please list all medications your child is currently taking (including over the counter medications):

_____

_____

With my signature, I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.