BROWNSBURG COMMUNITY SCHOOL CORPORATION

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April 12, 2010

Dear Parents/Guardians:

As you may have heard, the Indiana State Department of Health has updated requirements for immunizations for your child to attend school next year, starting in August of 2010.

Your child will be required to have the following Immunizations:

- A second Varicella vaccine or a documented history of the disease (chicken pox)
- Tdap-- tetanus/diphtheria/pertussis booster after the age of 10
- Meningitis

Vaccination is the best way to protect your child from potentially serious disease. The Hendricks County Health Department, in conjunction with the Indiana State Department of Health, is working with your child's school to provide these vaccines **FREE OF CHARGE** during school hours. Brownsburg Community School Corporation will hold vaccination clinics at the following locations for the following students only:

- Brownsburg High School Grades 9 through 11: April 28th and 29th from 8am until 2pm
- Brownsburg East Middle School Grades 6 through 8: April 30th from 8am until 2pm
- Brownsburg West Middle School Grades 6 through 8: April 30th from 8am until 2pm

The vaccine consent form includes options allowing you to either accept or refuse these vaccinations for your child. If you're child **does not need** or you **refuse** these vaccinations at this time, please complete section A of the form and sign the bottom. It is mandatory that your child return the form regardless.

If you choose to have your child vaccinated, read the "What you need to know" forms included with this letter about the diseases and the vaccines. You must then **complete each section of the form**, sign at the bottom with the date and **return it to the school by FRIDAY, APRIL 16th.** If you are not sure which of these vaccinations your child needs to receive, please call your health care provider or your child's school. Again, these vaccines will be given to your child during the school day listed above.

If you have any questions about the vaccine or the vaccination clinics, please call:
Sarah Batista, Public Health Investigator, Immunization Division, Indiana State Department of Health
(317) 519-2058

Also, please feel free to contact the school nurse for your child's school with any questions or concerns.

Sincerely,
Macey Ward RN BSN
Director of Health Services
BCSC
Harris Academy Rm. 125
317-852-1010 X 1628
maceyward@brownsburg.k12.in.us

Adolescent School Immunization Clinic Parental Consent Form

School Name ____ Clinic Date ________________________________

In order for your child to obtain the adolescent vaccinations during this school based clinic, you must
1. **Complete** all appropriate sections 2. **Sign & Date** this form 3. **RETURN** this form to the school by **APRIL 16th, 2010**

A. INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT)

Student's Name Last ___________________________ First __________________ Middle __________________

Student's Birth Date ______________________________________ Age ___________________ Gender *Male* *Female*

Parent/Guardian Name Last ___________________________ First __________________ Relationship ______________

Student's Address _______________________________________ City ___________________ Zip Code ________________

☐ **I DO NOT WISH MY CHILD TO BE VACCINATED AT THIS TIME.** PARENT SIGNATURE REQUIRED AT THE BOTTOM.

B. VACCINE ELIGIBILITY SCREENING (PLEASE CHECK APPROPRIATE BOX – ALL VACCINE PROVIDED IS FREE OF CHARGE)

- ☐ **Medicaid (Package A)** A child, 0 thru 18 years of age, who has Medicaid Package A or Hoosier Healthwise. The parent does not pay a premium for the insurance.
- ☐ **Medicaid (Package C)** A child, 0 thru 18 years of age, who has Medicaid Package C. The parent pays a premium for the insurance.
- ☐ **American Indian/Alaskan Native** A child, 0 thru 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance.
- ☐ **No Health Insurance** A child, 0 thru 18 years of age, who does not have health insurance.
- ☐ **Limited Health Insurance** A child, 0 thru 18 years of age, who has health insurance, but the health insurance does not pay for vaccine coverage or the parent does not know if the insurance pays for vaccine coverage.
- ☐ **Insured** A child, 0 thru 18 years of age, who has health insurance which provides coverage for vaccines.

C. VACCINE HEALTH SCREENING (CIRCLE YES OR NO)

Please answer all questions about the student who will be receiving the vaccine(s). Answers will determine whether the student can be vaccinated at this time. If you respond 'Yes' to any of the questions, please explain in the space provided.

Yes No 1. Does the student have any allergies to medication, foods, or any vaccines?
Yes No 2. Has the student had a serious reaction to a vaccine in the past?
Yes No 3. Has the student had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?
Yes No 4. Has the student had a seizure, brain or other nervous system problem, including Guillain-Barré Syndrome?
Yes No 5. Does the student have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?
Yes No 6. Has the student taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?
Yes No 7. Has the student received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?
Yes No 8. Is the student pregnant or is there a chance she could become pregnant during the next month?
Yes No 9. Has the student received vaccinations in the past four (4) weeks?

Please explain any 'Yes' responses. ____

D. CONSENT TO VACCINATE

I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for the Meningococcal, Tetanus, Diphtheria, acellular Pertussis and/or Varicella (Chickenpox) vaccines. I have had a chance to ask questions and fully understand the benefits and risks of each of the indicated vaccines and ask the following vaccines be given to my child on the scheduled school clinic date (check all the apply):

☐ Meningococcal (MCV) ☐ Tetanus, Diphtheria, acellular Pertussis (Tdap) ☐ Varicella (Chickenpox)

I give permission to the Hendricks County Health Department, the Indiana State Department of Health, and/or their designees to vaccinate the student named on this form.

Signature of Parent/Guardian ____________________________________ Date ______________________________

Adolescent School Immunization Clinic Parental Consent Form

E. To Be Completed by Person Administering Vaccine

Vaccine	Manufacturer/Lot Number/ Expiration Date	Signature of Vaccinator	Site	Route	Date of VIS
MCV4			Left or Right Deltoid	IM	01-28-08
Tdap			Left or Right Deltoid	IM	11-18-08
Varicella			Left or Right Arm	SC	03-13-08

Entered into CHIRP By ____ Date ______________________________