Up-dated Scoliosis Guidelines from the

Alabama State Department of Education

and the

Alabama Department of Public Health

Scoliosis Guidelines were revised in January 2019. Schools in Alabama are required to offer and provide scoliosis screening for males and females in grades 5 through 9. The National Scoliosis Research Foundation estimates six million Americans have scoliosis. The goal of the spinal screening program is that children having spinal deformities be detected early and placed under medical care before serious disability and deformity occur.

Some Lee County schools conducted screening in the fall. Those schools who have not conducted the screening will send a letter home with the student which tells when the screening will be conducted at their school and a permission form to send back to the school giving permission to do the screening.

Please note: Forms not returned will result in student not being screened. Please call your school nurse if you have any questions.

Parent or Guardian of: _____

Vaccine consent form must be returned by: _____

Dear Parent / Guardian,

Students entering the 6th grade will require an additional dose of TDAP (tetanus-diphtheria toxoid & acellular pertussis) vaccine. Students must have this vaccine in order to enter 6th grade. This law became effective 2010 and may be found in Rules of the State Board of Health, Chapter 420-6-1.03(a).

If you would like to participate in our School Located Vaccination Clinic – **complete in full and sign** the consent form on the back of this form. Be sure to check the vaccines desired on the top of the form, if not checked- we will provide the ACIP recommended vaccines that your child is currently due for. There is no charge to parents for this service. If your child has Medicaid, AllKids, or private insurance, HNH will bill the insurance company for the vaccine. If your child is uninsured, the vaccine will also be given free of charge.

If your child is covered by PEEHIP – we cannot provide vaccinations for you. We apologize for this inconvenience- please contact PEEHIP at 1-877-517-0020.

Please see www.immunize.org or www.cdc.gov for current Vaccine Information Statement or more information regarding each of the vaccines recommended by CDC Advisory Committee on Immunization Practices (ACIP).

The following ACIP recommended vaccinations are available at the upcoming school located clinic:

Checked below are vaccines that your child should receive *(School Nurse- please use ImmPrint forecast to indicate non compliant vaccinations)*

- Tdap- Tetanus, diphtheria, pertussis : Ages 11-12 (also 10 years old and entering 6th grade)
- HPV- Human Papillomavirus: Ages 11-12 with a second dose after 6 months
- MCV- Meningococcal ACWY: Ages 11-12 with a booster dose recommended at age 16
- MCVB – Meningococcal B: Ages 16-18 with a second dose after 30 days

Please return the consent form – completed – with the desired vaccines checked – only if you wish for your child to be vaccinated during the school clinic- if not, please discard this form and make an appointment with your child's healthcare provider, local health department or pharmacy.

Feel free to contact us at 205-609-0268 with any questions or concerns,

HNH Immunizations Inc.

WWW.HEALTHHEROUSA.COM

HEALTH HERO

You Keep Them Smart
We Keep Them Healthy

School Clinic 4-18-19

Vaccine Consent Form

HEALTH HERO
You Keep Them Smart
We Keep Them Healthy

Please select the vaccine(s) you consent for your child to receive:

Tdap ☐ MCV ☐ MCV-B ☐ HPV ☐

PLEASE COMPLETE ALL OF THE INFORMATION BELOW **Please print using ink** (Incomplete forms will not be accepted)

FIRST NAME of Student:	**LAST NAME of Student:**
Gender: Male Female **Birthdate:** (month, day, year)	**Age** **Homeroom Teacher / Grade**
Address	**Phone # ( )**
City **Zip Code** **State**	**Student Race:** (Circle one) African American / Black White Alaskan/ Native American Asian Hispanic Non-Hispanic Hawaiian / Pacific Islander Other :
Email address:	

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.

Please fill out the following questions pertaining to your child's Health Insurance:

Insurance ☐ **Medicaid** ☐ **My child does NOT have health insurance** ☐	**Insurance Company:**
Policy Holder's First Name:	**Policy Holder's Last Name:**
Member ID:	**Policy Holder's Date of Birth: (month/day/year)**

CHECK YES OR NO FOR **EACH** QUESTION

YES	NO	
☐	☐	1. Has your child ever had a life threatening reaction(s) with any vaccines?
☐	☐	2. Does your child have any allergies to latex?
☐	☐	3. Has your child ever had a condition called Guillain Barré Syndrome (GBS)?
☐	☐	4. Has your child ever had seizures or another nervous system problem?
☐	☐	5. If applicable, is the student pregnant or nursing?

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL US AT 205-609-0268 TO SPEAK TO A REPRESENTATIVE.

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release the school system, HNH Immunizations, Inc. & subsidiaries, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. Clinic dates can be obtained from the school. I understand that the health related information on this form will be used for insurance billing purposes and your privacy will be protected.

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____ Date _____