Jefferson Regional

1600 W. 40th Ave.

Pine Bluff, AR 71603

870-541-7100

Dear Students and Parents,

On Thursday, July 22, Jefferson Regional Medical Center will be on the campus of White Hall Middle School from 1:00 pm to 4:00 pm to provide COVID-19 vaccines to those students 12 and older who have parental permission to receive the vaccine. The attached paperwork needs to be completed and returned to the school by Monday, July 19 if at all possible. If you are unable to complete and return the paperwork by July 19, walk-ins will be accepted on July 22. Jefferson Regional will be giving the Pfizer vaccine.

If your student receives their first COVID-19 vaccine on Thursday, July 22, their second dose will be due on Thursday, August 12. Jefferson Regional will return to the campus from 2:00 pm to 5:00 pm to give these second doses. No additional paperwork will be required at that time. If your student is unable to return to White Hall Middle School on Thursday, August 12 for the second dose, you can contact our Healthworks Clinic at (870) 541-8621 to make an appointment for their second dose. Healthworks is located at 4747 Dusty Lake Drive in Pine Bluff and gives vaccines Monday-Friday from 8:30am-4:30pm.

If you or another member of your family has not received their COVID-19 vaccine yet, please feel free to contact Healthworks and make an appointment.

The Arkansas Department of Health has said that any student who is fully vaccinated will NOT have to be quarantined if they come in to contact with a COVID positive student. Students who receive their second dose on August 12 will be considered fully vaccinated on August 26, 2021.

Thank you for allowing us the opportunity to provide this service to the students in the White Hall School District.

Sincerely,

Jefferson Regional

Jefferson Regional

COVID-19 Pfizer Vaccine Consent Form

Section 1: Information about Child to Receive Vaccine (please print)

Student's Name (Last)	**(First)**	**(M.I.)**	**Student's Date of Birth** **Month____ Day____ Year____**	
Parent/Legal Guardian's Name (Last)	**(First)**	**(M.I.)**	**Student's Age**	**Student's Gender**
Address	**Parent/Guardian Daytime Phone Number:**			
City	**State**	**Zip**		
Student's Doctor's Name (Last, First)	**Address**			
Student's Social Security Number	**Race**	**School**		
Insurance Provider		**Group Number**		
Policy Number	**Subscriber Information**	**Guardian's Social Security Number**	**Guardian's Date of Birth**	

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if your child can get the COVID-19 vaccine. If you answer "NO" to all of the following questions, your child can probably get the COVID-19 vaccine. If you answer "YES" or "Don't Know" to one or more of the following questions, your child may be able to get the COVID-19 vaccine, but we will contact you to discuss your options. Please mark YES, NO, or DON'T KNOW for each question.

	YES	NO	DON'T KNOW
1. Has your child ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) ☐ Polyethylene glycol (PEG), which is found in some medications, such as laxative and preparations for colonoscopy procedures ☐ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids. ☐ A previous does of COVID-19 vaccine ☐ A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but is not know which component elicited the immediate reaction	☐	☐	☐

	YES	NO	DON'T KNOW
2. Has your child ever had an allergic reaction to another vaccine (other than COVID-19) or injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
3. Has your child ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? (This would include food, pet, venom, environmental, or oral medication allergies.)	☐	☐	☐
4. Has your child received any vaccine in the last 14 days?	☐	☐	☐
5. Has your child ever had a positive test for COVID-19 or has a doctor ever told you that they had COVID-19?	☐	☐	☐
6. Has your child received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
7. Does your child have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
8. Does your child have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
9. Is your child pregnant or breastfeeding?	☐	☐	☐
10. Does your child receive frequent lip or face dermal fillers?	☐	☐	☐

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION

I have read or had explained to me the COVID-19 Pre-vaccination Checklist and understand the risks and benefits.

☐ **I GIVE CONSENT to Jefferson Regional Medical Center and its staff for my child named at the top of this form to be vaccinated with this vaccine. I understand that this is a two dose series and Jefferson Regional will return to the school in three (3) weeks to provide the second dose of vaccine. (By signing this consent you agree for your child to receive both doses of the vaccine.)**

Signature of Parent/Legal Guardian _____

Date: month _____ day _____ year _____

For Jefferson Regional Use. Do NOT write in this box.

Vaccine Information:
Type Viral Vector Product _COVID 19 ___Manufacturer ___Pfizer____ Lot Number _____Exp. Date _____
Date Administered _____ Administration Site: Left Arm / Right Arm Administration Route _____
Contraindications Identified No_____ Yes _____
Dose Number _____1_____ Signature _____

Vaccine Information:
Type Viral Vector Product _COVID 19 ___Manufacturer ___Pfizer____ Lot Number _____Exp. Date _____
Date Administered _____ Administration Site: Left Arm / Right Arm Administration Route _____
Contraindications Identified No_____ Yes _____

Dose Number _____2____ Signature _____

Jefferson Regional

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful.

REGARDING INSURANCE
We bill insurance as a courtesy to our patients. The balance is your responsibility whether your insurance pays or not. It is your responsibility to give us your accurate and up to date insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do not accept assignment of benefits we require that you pay up front for the non-covered portion. Please be aware that some of the services provided may be non-covered and/or not considered reasonable and necessary under the Medicare program and/or other medical insurance and will be your responsibility.

SELF PAY PATIENTS
Payment in full is due at the time service is rendered unless prior arrangements have been made.

Please understand that your bill is considered a part of your treatment. In order to provide service to all of our patients, timely payment is considered crucial. Unless prior arrangements have been made we will refer your account to a collection agency after 120 days.

I understand and agree to the above financial policy and hereby authorize Jefferson Hospital Association and rendering practices permission for treatment and to file my insurance for services.

DELINQUENT ACCOUNTS
I understand that delinquent accounts may be assigned to a credit reporting collection service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN
I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to Jefferson Hospital Association and rendering practices when they accept assignment.

CONSENT FOR TREATMENT
I hereby authorize the attending physician and/or medical staff at Jefferson Hospital Association and rendering practices to render any necessary professional services including examination, treatment and ancillary services.

CONSENT TO PHOTOGRAPH
I understand that photographs, videotapes, digital or other images may be recorded to document my care and I consent to this. I understand that JRMC will retain the ownership rights to these photographs, videotapes, digital and other images but I will be allowed to view them or obtain copies. I understand these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in JRMC's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

EPRESCRIBING CONSENT

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

FORMULARY AND BENEFIT TRANSACTIONS - Give the prescriber information about which drugs are covered by the drug benefit plan.

MEDICATION HISTORY TRANSACTIONS - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

FILL STATUS NOTIFICATION - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled. By signing this consent, you are agreeing that JRMC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

I hereby provide informed consent to JRMC to enroll me in the ePrescribe program. I understand all of the above. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

HIPAA COMPLIANCE

I attest I have received a copy of Jefferson Hospital Association and rendering practices compliance with regards to the Health Insurance Portability and Accountability Act.

Cardiology Associates
Healthworks
Endocrinology of South Arkansas
GI Associates
Children's Clinic of Southeast Arkansas
JRMC Neurology
OB/GYN Associates of South Arkansas
Pine Bluff Specialty Clinic
South Arkansas Orthopaedic Center
Surgical Associates of Southeast Ark
Family Health Associates of Southeast Arkansas.
Jefferson Regional Cancer Center
Urgent Care Clinic

Printed Name: _____

Patient Signature: _____

Date: _____