NEWPORT NEWS PUBLIC SCHOOLS

NNPS Health Services Department & Health District

MIDDLE & HIGH SCHOOL VACCINE CLINICS

March 21, 2022

Dear Parents/Guardians of Middle and High School Students,

Newport News Public Schools is collaborating with the Health Hero to provide the Tdap and meningococcal vaccines to 6th-12th grade students during the school day with signed parental consent. The school division and Health Hero will conduct onsite Tdap (Tetanus, Diphtheria and Pertussis) and meningococcal vaccine clinics at NNPS middle and high schools in April (see schedule on the reverse side). State law requires that all students receive the Tdap and meningococcal vaccines before entering 7th grade as well as one dose of meningococcal after the age of 16 for entry into 12th grade. All middle and high school students missing these vaccines may participate.

This is the only time Health Hero will be able to come to Newport News Public Schools, so families are encouraged to take advantage of this opportunity. Parents and guardians are **not** required to be present during the vaccine clinics. To ensure your child receives the vaccine, please **read, complete and sign both sides of the consent form.** Please be sure to complete the insurance information on the front side of the form and answer the yes or no question on the back of the form. The shots will be administered at no cost to you.

Please have your child return the form to school as soon as possible. You will receive confirmation of this vaccine for your records, which will also be submitted to the Virginia State Immunization Database.

As a reminder, all students are required to present written proof of having received a Tdap booster and meningococcal shot or proof of exemption signed by a medical provider, before they can start seventh and twelfth grade. No other shot is acceptable. If proof is not provided or if your child has not received the Tdap booster shot, he/she will be excluded from school on the first day, August 29, 2022, in accordance with state law.

Thank you for your attention to this very important matter. If you have questions or need any assistance, feel free to contact your school nurse.

Sincerely,

Nancy J. Carlson

Nancy J. Carlson, RN, BSN
Supervisor, Health Services

(Las formas en español pueden ser enviadas a casa con su niño. Asegurese que el estudiante las pida)

2021-2022 MIDDLE & HIGH SCHOOL
Tdap/MENINGOCOCCAL VACCINE SCHEDULE

Newport News Public Schools and Health Hero will be conducting shot clinics according to the schedule below**.**

Wednesday, April 27

Time	Team 1	Team 2
7:30 am	Warwick HS	Woodside HS
9:30 am	Heritage HS/Huntington MS	Ella Fitzgerald MS
11:30 am	AAD M & H	Passage MS
1:15 pm	Crittenden MS	Gildersleeve MS

Thursday, April 28

Time	Team 1
7:30 am	Denbigh HS
9:30 am	Menchville HS
11:30 am	Enterprise/PO
12:30 pm	Hines
2:00 pm	Washington MS

Please return completed form back to your school by

Wednesday April 13

PARENTAL CONSENT FORM

Newport News, VA
2022

HEALTH HERO — You Keep Them Smart / We Keep Them Healthy

Tdap & Meningococcal Vaccination at school **NO out of pocket cost to you***

Virginia State Law requires the Tdap booster and Meningococcal Vaccine. Tdap given prior to entry into 7th grade and Meningococcal given prior to entry into 7th **AND** before entry into 12th grade. This voluntary clinic will be held at NNPS. Please accurately fill out this Parental Consent Form 100% and return it back to your school. If you have questions please contact your school nurse or email Corp@HealthHeroUSA.com.

Student Info: If form is incomplete or unreadable this student may **NOT** be vaccinated. Print neatly in ink, ALL CAPS - One letter per box.

***IMPORTANT:* Please list Student's full name EXACTLY as shown on the Medical ID card.**

First Name																**Middle Initial**	
Last Name																	
Student Birth Date	M	M	/	D	D	/	Y	Y	Y	Y	AGE		Gender (M / F)		Grade		
School Name											Home Room Teacher						
Student Race Please Circle	American Indian / Alaskan Native		Black / African American		Asian		Native Hawaiian / Pacific Islander		White		Other		Student Ethnicity Please Circle		Hispanic or Latino		Not Hispanic or Latino

Insurance information: IMPORTANT please read carefully.

*This service is offered at no cost to you provided accurate information is given. Any changes to your insurance coverage (Insurance Provider, Coverage loss, Member ID, etc.) please email insurance updates to Corp@HealthHeroUSA.com along with your Student's full name, birthdate and the school name. Please provide updates prior to clinic date. Please do **NOT** call the school with insurance information updates. Your accuracy helps us continue this beneficial program for your family, school and community. We encourage you to make a photocopy of this form foryour records.

1 If student has **NO MEDICAL INSURANCE** coverage check this box. ☐ Do not check this box if student is covered under Medicaid.

It is considered fraud to check this box if student is covered under private insurance or Medicaid.

2 If student is enrolled with **MEDICAID** - Please fill out student's Medicaid information. **Circle students Medicaid MCO provider.**

Anthem HealthKeepers Plus **Molina *Complete Care*** **Virginia Premier** **Aetna *Better Health***

UnitedHealthCare *Community Plan* **Optima Health *Family Care*** **Magellan**

Students Medicaid Number												

** (Must Provide **student's 12** digit Medicaid # above.)

Students MCO Insurance Identification #

*If this student is enrolled in the Medicaid FAMIS program and you pay a small copay when seeing a doctor please put an **X** in the FAMIS box. If you put an **X** in the box to the right, this student's Medicaid MCO FAMIS card must have this symbol on the front of the card. FAMIS ☐ FAMIS

3 If student has **PRIVATE** medical insurance ONLY through a Parent or Guardian - Please fill out Parent/Guardian's information below. Fill out Section 2 above if Student has coverage through Medicaid.

Insurance Co Name **(NOT Medicaid)**		TOLL FREE# on back of the insurance Card	
Insured **ADULT** Full Name		Insured **ADULT** Birth Date	M M / D D / Y Y

A Member ID # or Policy #

Please also complete box **B** or **C** below if student has TriCare insurance. Box **B** is an 11 digit DBN Benefits # with the last 2 digits identifying this specific dependent. Box **C** is the sponsor's SSN.

B TriCare DBN Benefits # — **C** TriCare SSN

*BOX A - Include all letters & numbers that are part of the student's Member ID and include any Numbers after a * Star or - Dash.*

Turn Over & Fill Out Backside

Parent / Guardian: Do any of the following apply to your Child?

	YES	NO
- This Child is allergic to latex.		
- This Child faints after getting any vaccine shot.		
- This Child has a history of Guillain-Barre Syndrome.		
- This Child has a severe allergy to components in these vaccines.		
- This Child has an unstable neurological disorder such as epilepsy or seizures.		
- This Child was in a coma or had long repeated seizures 7 days after a childhood dose of DTP, DTaP, or Tdap.		
- This Child had a life-threatening allergic reaction after receiving a dose of any diphtheria tetanus or pertussis containing vaccine.		
- This Child is pregnant.		

If you answered Yes above this student cannot receive this vaccine at school. Please contact student's doctor for required vaccinations and PLEASE do not turn in this consent form.

Authorizing Parent or Guardian: If form is **incomplete** or **unreadable** this student may **not** be vaccinated. Print Neatly ALL CAPS

First Name		Last Name		Circle Parent Guardian
Street Address		City		Zip
Parent / Guardian Phone #	- -	Email Address (for clinic info only)		

STUDENT NAME: (please print) _____ STUDENT BIRTHDATE: ____ / ____ / ____

I, the undersigned, as the parent/legal guardian of the student named above, having the legal authority to make medical decisions on their behalf, or if over 18 years old for myself, do hereby give my full consent for this student or myself to receive the vaccine. I have read the information about the vaccine and 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 (Tdap) or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I acknowledge there are no guarantees concerning the vaccines' success. Additionally, I do hereby waive, release and hold harmless Newport News VA Public School system, Health Hero USA LLC & subsidiaries, their owners, directors, contractors and employees from any liability or potential cause of action with respect to any bodily, injury, disability, death, or loss or damage to person occurring as a result of participation in the vaccination program and the activities incidental thereto, whether the result of negligence or any other cause. Further, I understand Newport News VA Public School system, Health Hero USA LLC & subsidiaries, their owners, directors, contractors and employees shall not be liable in any way. I am solely responsible for any associated medical costs. I further certify that this student or myself have no medical or physical condition that could interfere with safely receiving the vaccine, or else I certify that I am willing to assume risks and bear the costs that may be created, directly or indirectly, by any such condition. I understand this consent is valid for six months and that I will update Health Hero USA via email Corp@HealthHeroUSA.com of any health, insurance coverage or insured insurance information changes prior to the vaccination clinic date. Please do not contact the school or district office with any updates. I affirm that I will be responsible to reimburse Health Hero USA LLC for vaccination services, any collection and legal costs as a result of it's inability to bill Insured's insurance company due to inaccurate patient or insurance information provided. I assign Health Hero USA LLC the rights to file claims for services rendered and to adjudicate /appeals with the name insured. Your Clinic date can be obtained from the school. Any controversy or claim arising out of this Agreement shall be settled by arbitration in Mecklenburg County, North Carolina in accordance with then-governing rules of the American Arbitration Association. The arbitrator(s) shall be bound by the Agreement and shall interpret the Agreement in accordance with the applicable laws of the United States and the internal laws of the State of North Carolina. Any award, order, or judgment made pursuant to such arbitration shall be deemed final and shall be entered and enforced in any court of competent jurisdiction. I understand the health related information on this form may be governed by the regulations established under the Health Insurance Portability and Accountability Act of 1996. Confidential health information will be used and disclosed solely for insurance billing and reporting purposes. I certify that the information provided on this form is true and accurate. I have had sufficient opportunity to read this entire document, I have read and understood it, and I agree to be bound by its terms.

Consent by Parent / Guardian—I consent to let Health Hero give the following vaccine(s) to my child: (please check each vaccine needed)

☐ Tdap vaccine (required before entering into 7th grade)

☐ Meningococcal vaccine (required before entering into 7th grade and before entering 12th grade)

MUST SIGN & DATE _____ Parent or Guardian Signature _____ Date

For Administrative Use Only

Vaccine Lot #	Vaccine Lot #
Vaccine Expiration Date:	Vaccine Expiration Date:
Y B	Y B
_____ clinic date	_____ clinic date
Left Arm	Right Arm
CDC VIS Meningococcal 8/6/2021	CDC VIS Tdap 8/6/2021
nurse_____	nurse_____