State of Kansas
House of Representatives

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Francis Awerkamp
State Representative, 61st District

Madam Chair,

Thank you for allowing my testimony on HB 2121. In my testimony I will ask that you consider amending this bill to give clarifications that I believe would be helpful to both patients and their doctors.

HB 2121 adds a requirement for doctors regarding vaccine registry but does not include any wording about the patient's consent being needed before their personal information is registered. When this bill was presented, there was an assumption made by the carrier of the bill that patient consent was not affected. I believed the wording of the bill is contrary to that assumption.

When the bill was being debated on the House Floor I offered an amendment that added two clarifications. They are:

1. A requirement for a patient's consent before a patient's information could be entered into the State registry, and
2. A requirement that the patient information form must list the patient's consent for the registry of their information as a separate consent and not be combined with other consent(s).

My amendment failed (my guess is that the reason it failed is because I am a rookie).

Attached to this testimony are the amendment and also a sample form used for patient consent. I believe the amendment respects the original intent of the bill while also showing necessary respect to patient's privacy rights. The attached patient consent form (provided by KDHE) shows that currently the sample form has the consent for vaccine registry included in the consent to receive a vaccine. I believe that these consents must be separated as they are two separate issues.

I respectfully ask that my amendment be considered. Thank you again Madam Chair for allowing my testimony in your committee.

Respectfully,

Representative Francis Awerkamp

STATE OF KANSAS

HOUSE OF REPRESENTATIVES

MR. CHAIRMAN:

I move to amend HB 2121, as amended by House Committee, on page 1, in line 6, after "report" by inserting "subject to the consent requirements of subsection (b)";

Also on page 1, in line 10, after "(b)" by inserting "No report of the administration of a vaccine under subsection (a) shall be made unless the person to which the vaccine was administered consents in writing to the report. If the person to which the vaccine is administered is less than 18 years of age, no report under subsection (a) shall be made unless the parent or guardian of the person consents in writing to the report or, if a parent is not available, consent is obtained in accordance with K.S.A. 38-137, and amendments thereto. If a consent form or other printed document is used to obtain the consent, the printing on the form or document relating to the consent shall be separate from any other consent, shall be plain and clear and shall be the same size or larger print than the other printing on the form or document.

(c)"

_____

_____District.

VACCINE DOCUMENTATION/CONSENT FORM

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

☐ DTaP/DT/TdaP/Td ☐ HepA ☐ HepB ☐ Hib ☐ HPV ☐ Influenza ☐ Meningococcal ☐ MMR

☐ PCV13 ☐ PPV23 ☐ Polio/IPV ☐ Rotavirus ☐ Tb ppd ☐ Varicella Other _____

Signature of Patient or Parent/Guardian _____ Date _____

PATIENT INFORMATION

Patient's Last Name:	Patient's First Name:	(ID):	Phone Number:	Age:	Birth Date	Gender [ ] MALE [ ] FEMALE	Ethnicity: Hispanic or Latino [ ] Yes [ ] No

PATIENT ADDRESS	PHYSICIAN	PATIENT ELIGIBILITY * ** ^	RACE (Select one or more.)
Address: County:	Primary Care Physician: Physician Contact Information:	☐ TITLE 19 (<19yrs) [Medicaid] ☐ Uninsured (<19yrs) ☐ American Indian/Alaskan Native(<19yrs) ☐ Underinsured (<19yrs) [RHC/FQHC/HD only] ☐ Fully Insured (<19yrs) ☐ Uninsured Adult ☐ Fully Insured Adult ☐ Underserved (<19yrs) [HD Only] ☐ TITLE 21 (<19yrs) [SCHIP-STATE] ☐ VFC Eligibility not Determined/Unknown	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown or Not Reported ☐ White ☐ Other

*Underinsured children: Insurance does not cover immunizations. Eligible through VFC program if vaccinated at a FQHC, RHC, or county health dept.

**Underserved children: Are not VFC Eligible. May only be vaccinated with KIP vaccines needed for school entry at a county health dept if enrolled in federal free or reduced-price school lunch program.

^ Underserved and Underinsured children are eligible through state funded vaccine program if vaccinated at a public county health clinic.

IMMUNIZATION SCREENING QUESTIONNAIRE

1. Is the patient to be vaccinated currently sick or experiencing a high fever?	☐ Yes ☐ No	7. Has the patient, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐ Yes. ☐ No
2. Does the patient have allergies to medications, food, a vaccine component, or latex?	☐ Yes ☐ No	8. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes. ☐ No
3. Has the patient had a serious reaction to a vaccine in the past?	☐ Yes ☐ No	9. In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐ Yes. ☐ No
4. Has the patient had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐ Yes ☐ No	10. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ Yes. ☐ No
5. If the patient to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐ Yes ☐ No	11. Is the patient pregnant or is there a chance she could become pregnant during the next month?	☐ Yes. ☐ No
6. If your patient is a baby, have you ever been told he or she has had intussusceptions?	☐ Yes ☐ No	12. Has the patient received vaccinations in the past 4 weeks?	☐ Yes. ☐ No

PROVIDER INFORMATION

Vaccine Provider:		Clinic Site:	
Address:		Address:	
Phone Number:	County:	Phone Number:	County:

PATIENT INFORMATION

Patient's Last Name:	Patient's First Name:	(ID):	Phone Number:	Age:	Birth Date	Gender [ ] MALE [ ] FEMALE	Ethnicity: Hispanic or Latino [ ] Yes [ ] No

Vaccine Group	Vaccine	Vacc Date	Mfg	Vaccine Lot #	Exp Date	Site	Route	Administered By	Recipient Signature	VIS Date	VFC Code (below)
							Intradermal Intramuscular Intravenous Nasal Oral Other/Miscellaneous Subcutaneous Transdermal				

VACCINES FOR CHILDREN (VFC) CODES: 1=TITLE 19 (<19yrs) [Medicaid], 10=VFC Eligibility not Determined/Unknown, 2=TITLE 21 (<19yrs) [SCHIP-STATE], 3=Uninsured (<19yrs), 4=American Indian/Alaskan Native(<19yrs), 5=Underinsured (<19yrs) [RHC/FQHC/HD only], 6=Fully Insured (<19yrs), 7=Uninsured Adult, 8=Fully Insured Adult, 9=Underserved (<19yrs) [HD Only]