



Southwest Health District 2017-2018 Influenza Vaccine Consent Form/School-Based Flu Clinics

STUDENT'S NAME (Last)		(First)	(M.I.)	SCHOOL NAME:	
STUDENT'S DATE OF BIRTH (mm/dd/yyyy)		STUDENT'S AGE	GENDER: M / F		TEACHER
ETHNICITY (Please Circle) Not Hispanic/Latino Hispanic/Latino		RACE (Please Circle) African American, White, American Indian, Asian, Alaska Native, Native Hawaiian, Other Pacific Islander, Other		PARENT/ LEGAL GUARDIAN'S NAME	
HOME ADDRESS				PARENTAL/ GUARDIAN PHONE NUMBER(S)	
CITY	STATE	ZIP CODE	ALLERGIES		
INSURANCE INFORMATION: Do you have insurance that covers vaccines? Yes / No Check health insurance provider below. (You will not be charged for this vaccine.) <input type="checkbox"/> BCBS <input type="checkbox"/> AETNA/Coventry <input type="checkbox"/> Cigna <input type="checkbox"/> United Healthcare Policy/Group # _____ / _____ <input type="checkbox"/> Medicaid/Wellcare/Peachstate/Amerigroup/CareSource/Peachcare # _____ <input type="checkbox"/> No Insurance/Other: _____					

Section 2: Medical Information. The following questions will help us to know if this student can receive the 2017-2018 Influenza Vaccine. **Please circle Yes or No for each question.*

1. Has the student ever had a serious reaction to any influenza vaccine?	Yes	No
2. Has the student child ever had a serious reaction to eggs?	Yes	No
3. Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No
4. Is the student allergic to latex?	Yes	No

Section 3: Consent:

***If you selected YES TO QUESTION 1 - 3 in section 2 your child WILL NOT be able to receive INJECTABLE flu vaccine at school.*
Contact your healthcare provider regarding flu vaccine for your child**

CONSENT FOR STUDENT TO RECEIVE INFLUENZA VACCINE: *By signing below, I give permission for the student named above to receive the 2017-2018 Influenza vaccine.* I acknowledge the student and medical information provided above is correct. I have been given a copy of the Vaccine Information Statements (VIS) dated 08/07/2015 for the influenza vaccines and I understand the NOTICE OF PRIVACY PRACTICES and have been provided with a copy for my review. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine that will be given to the student I am authorized to represent. I understand participation and receipt of the influenza vaccine through this program is completely voluntary. By signing below, I give permission for the student listed above to receive the Injectable Influenza Vaccine. **The consent form will provide permission to vaccinate for both doses, if needed. (See VIS) If this consent form is not filled in completely, signed, dated, and returned, the student will not be vaccinated at school.**

Signature of Parent/ Legal Guardian: _____ Date: _____

Health Department Staff Use Only

Type Vaccine	Date Administered	Mfg. /Lot#/Exp. Date	Administration Route	Nurse Signature	
1 st Inactivated: VFC /CP	1 st _____	1 st _____	IM / LD/LM RD/RM	1 st _____	GRITS Check: Date and Verified By: _____
2 nd Inactivated: VFC/CP	2 nd _____	2 nd _____	IM / LD/LM RD/RM	2 nd _____	
Allergy Status Verified	Right Vaccine/No contraindications	Right Formulation for Patient's Age	Right Patient/Verify @ Minimum Name and DOB	Expiration Date Valid	Right Dose/Route