Southwest Health District
2015-2016 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	GRADE
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.) ☐ BCBS ☐ AETNA/Coventry ☐ Cigna ☐United Healthcare SHBP Policy/Group # _____/_____
☐ Medicaid/Wellcare/Peachstate/Amerigroup/Peachcare # _____ ☐No Insurance/Other: _____

Section 2: Medical Information. The following questions will help us to know if this student can receive the 2015-2016 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. a.) Does the student have asthma or a wheezing condition? b.) If YES, does your child use inhalers and/ or breathing treatments?	a. Yes b. Yes	a. No b. No
5. Is the student on long-term aspirin or aspirin-containing therapy (For example: does your child take aspirin everyday)	Yes	No
6. Does the student have any significant or chronic (long term) health conditions? (For example: diabetes, sickle cell disease, heart conditions, lung conditions, seizure disorders, cerebral palsy, muscle or nerve disorders, etc.)	Yes	No
7. Does the student have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer?)	Yes	No
8. Is the student or could the student be pregnant?	Yes	No
9. Does the student live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	Yes	No
10. Has the student received any vaccines in the last four weeks? If yes, please list: _____	Yes	No
11. 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 OR INTRANASAL flu vaccine at school.* Contact your healthcare provider regarding flu vaccine for your child. *If you selected YES to any of QUESTIONS 4-9 in section 2, your child WILL NOT be able to receive the INTRANASAL vaccine and CAN ONLY RECEIVE the INJECTABLE vaccine.**

CONSENT FOR STUDENT TO RECEIVE INFLUENZA VACCINE: ***By signing below, I give permission for the student named above to receive the 2015-2016 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 08/19/2014 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 IntraNASAL or 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	Clerk initial/date entered in VHN
1st Intranasal: VFC /CP	1st _____	1st _____	Intranasal	1st _____	
2nd Intranasal: VFC/CP	2nd _____	2nd _____	Intranasal	2nd _____	
1st Inactivated: VFC /CP	1st _____	1st _____	IM / LD/LM RD/RM	1st _____	
2nd Inactivated: VFC/CP	2nd _____	2nd _____	IM / LD/LM RD/RM	2nd _____	
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**

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