



## School Based Influenza Vaccine Consent Form

### \_\_\_\_\_ County Health Department

#### Section 1: Information about Student to Receive Influenza Vaccine (please print)

STUDENT'S NAME (Last)	(First)	(M.I.)	SCHOOL NAME:	Student ID/Lunch No.:
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, Hispanic or Latino, American Indian, Asian, Alaska Native, Native Hawaiian, Other Pacific		PARENT/ LEGAL GUARDIAN'S NAME	
HOME ADDRESS			PARENTAL/ GUARDIAN PHONE NUMBER(S)	
CITY	STATE	ZIP CODE	PARENTAL/ GUARDIAN E-MAIL	
<b>INSURANCE INFORMATION: Do you have insurance that covers vaccines?</b> <input type="checkbox"/> Yes / <input type="checkbox"/> No <b>Please check health insurance provider below:</b> <input type="checkbox"/> Medicaid (Amerigroup, Wellcare, Peach State, Caresource) <input type="checkbox"/> Cigna <input type="checkbox"/> No Insurance <input type="checkbox"/> Peachcare(Amerigroup, Wellcare, Peach State) <input type="checkbox"/> United Healthcare <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> Coventry <input type="checkbox"/> Aetna <input type="checkbox"/> Secure Health <input type="checkbox"/> other _____			<b>Provide the insurance information for the provider selected &amp; attach a copy of the insurance card to this form</b> Policy Holder Name _____ Policy Holder Date of Birth _____ Group# _____ Member ID # _____	

#### Section 2: Medical Information: *The following questions will help us to determine if this student can receive the influenza vaccine.*

*\*Please circle Yes or No for each question.*

1. Has the student received any vaccines in the last four weeks? If yes, please list:	Yes	No
2. When was the student last vaccinated for flu?	<b>DATE:</b>	
3. Has the student ever had a serious reaction to eggs?	Yes	No
4. Has the student ever had a serious reaction to any influenza vaccine?	Yes	No
5. Does the child use an inhaler or receive breathing treatments for asthma or a wheezing condition?	Yes	No
6. Is the student on long term aspirin or aspirin-containing therapy (For example: does the student take aspirin everyday)	Yes	No
7. 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)	Yes	No
8. 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
9. Is the student or could the student be pregnant?	Yes	No
10. Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No
Comments:		

#### Section 3: Consent: *If this consent form is not filled in completely, signed, dated, and returned, the student will not be vaccinated at school.*

**I GIVE CONSENT** to the North Central Health District (NCHD) *for the student named above to receive the influenza vaccine.* I acknowledge that the student and medical information provided above is correct. I have been given a copy of the Vaccine Information Statements for the influenza vaccines. I have had a chance to ask questions which were answered to my satisfaction. I acknowledge that I have reviewed and understand the Notice of Privacy Practices for NCHD which is available at northcentralhealthdistrict.org or at my local health department. I understand the benefits and risks of the influenza vaccine that will be given to the student that I am authorized to represent. I understand that 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 influenza vaccine.

**Signature of Parent/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

#### FOR CLINIC USE ONLY

Influenza Vaccines	Date Dose Administered:	Mfg:	Lot #	Exp Date:	VIS Date:	Signature of Nurse:
<input type="checkbox"/> Quadrivalent (IIV <sub>4</sub> )	IM    LA / RA				08/07/15	_____ Date: _____
<input type="checkbox"/> FluMist	intranasal				08/07/15	Entry Clerk Initial: _____ Date: _____