-2	PARENT CONSENT FOR SEASONAL INFLUENZA VACCINATION										
Mahec	FOR CLINIC School USE ONLY District ID			School Name							
			NT INFORMAT	ION (u	se black ink onl	ly)					
STUDENT FIRST NAME	ľ	MI	STUDENT LAST NA	ME					AGE	GRADE	
DATE OF BIRTH (MM/DD/YYYY) / /	GENDER	FEMALE	SCHOOL				ŀ	HOMEROO	M TEACHE	R	
RACE		Asian 🗆 Bla White	ick/African Americ	an	E	ETHNIC		Hispanic o Not Hispa	or Latino nic or Latin	10	
STREET ADDRESS				CITY				STATE	ZIP		
PARENT/GUARDIAN FIRST NAME	PARI	ENT/GUARDIAN	N LAST NAME		PARENT/GUARI CELL TELEPH		()	-		
PARENT/GUARDIAN EMAIL ADDRE	SS				PARENT/GUAR HOME TELEPH		()	-		
		INSURANCE	INFORMATIO	N (Plea	se fill out com	pletel	y)				
	Enter Medicaio Continue comp	,	SC MEDICAID NU	IMBER							
		e information) ng questions))	VACCINE ☐ Ye								
PRIMARY INSURANCE	KIP to screenii	ig questions//	COVERED		SUBSCRIBER/INSU WORK TELEPHO)	-		
RELATIONSHIP TO THE SUBSCRIBER/INSURED SELF	SPOUSE	DEPENDENT	MEMBER/INSU	IRED ID				GROUP	ID		
SUBSCRIBER/INSURED FIRST NAME		SUBSCRIBER/I	INSURED LAST NAM	ME	SUBSCRIB	ER/INS /	URED DOB	(MM/DD/	YYYY)	GENDER □ M □ F	
		INFLUENZ	A VACCINATIO	N SCR	EENING QUEST	IONS	,				
The following questions will help u ask your healthcare provider to exp				ot give y	our child a seasonal	l influer	nza vaccina	tion. If a q	uestion is r	not clear, please	
Has your child ever had wheezing, trouble breat				-			-		-	NO YES	
2. Has your child ever had		· ·		-						NO YES	
If you answered YES to any of the healthcare provider about the flu	vaccine.					enza va	accine at so	hool. Plea	se contact	your primary	
If you answered NO to the above of the above						ld'c	DATE OF				
date of birth ONLY if you 4. If your child is under 9	ur child is und	er 9 years old.					BIRTH NO YES	UNSUR	/ F		
to July 1, 2017?	years ora, mas	your cima rece	ived at least two o	10363 01	iiiiiaeiiza vaeeiiie p	1101			_		
			AUTHORIZATIO								
By signing below, I consent to the undersignment of all payments from the insurance company will be charged following link: http://www.scdhec.	ne insurer liste I for the cost o	ed to the South of the vaccine b	Carolina Departm out there will be no	ent of H cost of	ealth and Environm the vaccine to you	nental C or your	Control (DH r child. DHE	EC) for the	e services r	endered. Your	
If applicable, by signing below, I repermission to exchange my child's other agents needed to determine services rendered.	medical or oth	ner confidentia	l information as ne	ecessary	to the Centers for I	Medica	re and Me	dicaid Serv	vices (CMS)	, its agents, or	
Vaccine Authorization: I voluntarilinfluenza vaccine at school, to be a following link: https://www.cdc.gc and benefits of the vaccine. I under understand that incorrect informat vaccine, administered by DHEC, at Prevention (CDC). In case of occupation information about my child will be individual indicated above, to cons SIGNATURE OF PARENT	dministered bov/vaccines/hov/va	y DHEC staff. I cp/vis/vis-state e vaccine will b se serious risks , if my child is l ire, I consent to C Immunization	have read the Vac ments/flu.pdf. I have given as a shot. I to my child. In addess than 9 years of my child's blood in Registry for publi	cine Info ave had a have re dition, I d and a testing i	ormation Statement an opportunity to a ad and answered th consent to my child second dose is reco f necessary for child	t. Vacci sk ques he ques I receivi ommen d and e	ne Informa stions abou stions abov ing a secon ded by the mployee sa	tion State t the vacci e carefully d dose of U.S. Cente afety. I und	ment can b ine. I under and accura the season ers of Disea derstand th	e found at the stand the risks ately, and I al influenza se Control and at immunization	
OR LEGAL GUARDIAN							DATE	/	/		

	VACCINA	TION DETAILS (Influenza	V04.81) FOR CLINIC USE ONLY	– BLACI	K INK ONI	LY			
	VACCINE ELIGIBILITY								
	□ IIV4 □ VFC > MEDICAID □ VFC > AMERICAN INDIAN/ALASKA NATIVE □ VFC > UNINSURED (NO INSURANCE)								
	☐ STATE > UNDERINSURED ☐ STATE > INSURED ☐ ADULT > NO HEALTH INSURANCE ☐ ADULT > UNDERINSURED ☐ FFS > INSURED ☐ FFS > MEDICAID ☐ FFS > NO HEALTH INSURANCE ☐ FFS > UNDERINSURED								
	MANUFACTURER	LOT NUMBER	FFS > NO HEALTH INSURANCE FFS	FFS > UNDERINSURED SITE OF ADMINISTRATION					
ш	SANOFI PASTEUR	LOT NOWIBER				VIIIVIS	RATION		
GLAXOSMITHKLINE									
☐ SANOFI PASTEUR ☐ GLAXOSMITHKLINE VIS DATE 08/07/2015					□ RD □ Other_				
	710 57112 00/07/2015	Nurse: I hereby attest by signature b	Nurse: I hereby attest by signature below that the patient (or guardian of patient) in						
S		question has been given the Influenz consent for vaccination.	a Vaccine Information Sheets and has given written	DATE	/	/			
NURSE SIGNATURE				ECODE			COUNTY		
							CODE		
	PATIENT'S/STUDEN	T'S Teacher: I hereby attest by signature	below that the identity of the patient in question has	5					
	ASSIGNED CLASSROO	been verified.			/	/			
	TEACHER SIGNATU								
	☐ "What to Know After'	given to student Una	ble to vaccinate due to	"Unable t	o Vaccinate	" forn	n given to student/school.		
	VACCINE ELIGIBILITY								
			NDIAN/ALASKA NATIVE	•					
			NSURED ADULT > NO HEALTH INSUR			NDER	INSURED		
ш	MANUFACTURER	LOT NUMBER	FFS > NO HEALTH INSURANCE ☐ FFS		SITE OF ADN	AINIICT	TDATION		
S	SANOFI PASTEUR	LOT NOWIBER				VIIIVIS	RATION		
\circ	☐ GLAXOSMITHKLINE				□ RD				
	VIS DATE 08/07/2015				☐ Other_				
			elow that the patient (or guardian of patient) in		,	,			
MANUFACTURER SANOFI PASTEUR GLAXOSMITHKLINE VIS DATE 08/07/2015 NURSE SIGNATURE		consent for vaccination.	a Vaccine Information Sheets and has given written	DATE	/	/			
		RSF					COUNTY		
SIGNATURE		IRE					CODE		
PATIENT'S/STUDENT'STead			below that the identity of the patient in question has	S					
ASSIGNED CLASSROOM been verified.		DMI		DATE	/	/			
	TEACHER SIGNATU "What to Know After"		ble to vaccinate due to	"I Inahle t	n Vaccinate	" form	n given to student/school		
	- What to know / wter	Siver to stadent	NOTES	Onable	o vaccinate	10111	T given to stadenty sensor		
			NOTES						
DDE (CLINIC CODEENING FO	D CLINIC LICE ONLY							
	CLINIC SCREENING – FC	R CLINIC USE ONLY							
FIRST DOSE E		ANTINIDIANI/ALACIZA NIATIVE							
□ VFC – MEDICAID □ VFC – AMERICAN INDIAN/ALASKA NATIVE □ VFC – UNINSURED (NO INSURANCE)									
□ STATE – UNDERINSURED □ STATE – INSURED			MCI NUMBER						
☐ ADULT > NO HEALTH INSURANCE ☐ ADULT > UNDERINSURED									
☐ FFS > IN	SURED ☐ FFS > MEDICAID								
☐ FFS > N	O HEALTH INSURANCE 🛛 F	FS > UNDERINSURED							
SECOND DOSE NEEDED?			STUDENT'S NAME						
	SE ELIGIBILITY								
□ VFC - MEDICAID □ VFC - AMERICAN INDIAN/ALASKA NATIVE									
□ VFC – UNINSURED (NO INSURANCE) □ STATE – UNDERINSURED □ STATE – INSURED			DATE OF BIRTH	/					
	- UNDEKINSUKED 🗆 STATE	– וואסטגבט	i						