



2014-15 STUDENT INFLUENZA VACCINATION CONSENT FORM



IV & LAIV or LAIV ONLY

Childs Name: Last First Middle Date of Birth

Age: Gender: M F

If minor - parent/guardian's name Last First M.I.

Parent's SSN: optional

Parent/Guardian's Date of Birth: Address: City: State: Zip:

IMPORTANT Parent/Guardian Phone # Home: Cell: Work:

School: Home Room Teacher: Grade:

Health Department Use Only
CI #:
Encounter #:
Receipt #:

Please check YES or NO to all of the questions below to determine if your child can receive the Intranasal Influenza Vaccine (FluMist - "nasal spray") or the Inactivated Influenza Vaccine ("flu shot").

- 1. Has your child ever had a serious allergic reaction to any component of any flu vaccine...
2. Has your child ever had a serious reaction to a previous dose of flu vaccine...
3. Has your child ever had Guillain-Barré syndrome (GBS, i.e., progressive ascending paralysis)?

If you answered YES to any of questions 1, 2 or 3 above about a serious allergy, reaction or GBS, flu vaccine may not be safe for your child and s/he WILL NOT receive a flu vaccine.

- 4. If your child is between 2 - 4 years, in the past 12 months has a healthcare provider ever told you that your child had wheezing or asthma?
5. Does your child have a long-term health problem such as heart disease, kidney or liver disease, lung disease, metabolic disease (e.g. diabetes), or blood disorders (e.g. anemia)?
6. Does your child have a weakened immune system because of cancer, cancer treatment (e.g. x-rays or drugs), HIV/AIDS, other disorders, or medicine (e.g. high dose steroids)?
7. Does your child live with or expect to have close contact with a severely immunosuppressed person requiring a protective environment (e.g., an isolation room of a bone marrow transplant unit)?
8. Is your child taking aspirin or other aspirin-containing products?
9. Is your child taking any prescription medications to prevent or treat flu?
10. Has your child received a MMR (measles/mumps/rubella) and/or varicella (chickenpox) vaccination within the past 4 weeks?
11. Is your child pregnant or could she become pregnant within the next month?

If you answered YES or left blank any questions from # 4 through # 11 or if your child is younger than 2 years old, your child WILL NOT receive FluMist, but she/he CAN RECEIVE the flu shot.

CONSENT FOR CHILD'S VACCINATION: In October 2014, will your child be less than 9 years of age? No Yes

Please complete the next set of questions and sign.

My child is over 9 years of age. I understand my child will receive one dose of influenza vaccine.

My child is under 9 years of age and:

has NEVER been vaccinated against the flu. Note: Your child will require 2 doses this year.

has not been vaccinated with at least 2 doses of seasonal influenza vaccine since July 1, 2010. Your child will require 2 doses this year.

*A second consent will be sent out for a 2nd dose in 4 weeks.

I have read the 2014-2015 Vaccination Information Statements (VIS) for the influenza shot and for the nasal spray. I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to get vaccinated with this vaccine. I prefer my child be given the

(please check one) flu shot, flu mist. I understand the decision on the type of vaccine administered will depend on my child's history.

Signature of Parent or Legal Guardian: X [Signature] Date: / /

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids in a way that may transmit disease, your child's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

Insurance*: Please answer the following: **Note:** This information is required for federal funding purposes for VFC vaccine. It will not prevent your child from receiving vaccines through this program.

Please check correct box below and fill in insurance number.

My child: () is *not* insured (by private insurance, Medicaid, or FAMIS) () is American Indian or is an Alaska Native
() has Medicaid - Medicaid #: _____ () has FAMIS - FAMIS #: _____

() has Anthem – Anthem # _____
Name of Insured/Policy Holder _____ *Insurance group #* _____
Relationship of policy holder _____ *D.O.B. of Policy Holder* _____

() has Medicaid MCO's – Medicaid MCO # _____
Check below which MCO that your child has.

___ Anthem HealthKeepers ___ Optima Family Care ___ Virginia Premier ___ Coventry Care ___ Majestacare
___ Intotal Health (formerly Amerigroup)

() has Affordable Care Act – Affordable Care Act # _____
Check below If your child has Affordable Care Act Insurance

___ Anthem HealthKeepers ___ Optima Family Care ___ Virginia Premier ___ Coventry Care ___ Majestacare
___ Intotal Health (formerly Amerigroup)

I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third party payer to pay any authorized benefits to VDH on my behalf.

Signature: X 

Office of Privacy and Security Authorization for Disclosure of Protected Health Information

Please check box if you wish to receive a copy of the Virginia Department of Health Privacy Rights

As the person signing this authorization, I understand that I am giving permission to the Virginia Department of Health (VDH) to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to me cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that this record will be retained for ten years after the last visit or for five years after age 18, whichever comes later. I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third party payer to pay any authorized benefits to VDH on my behalf.

I understand that the Virginia Department of Health will not release private medical records unless authorized above or to continue care.

_____ X  _____
Please Print Your Name **Signature** **Date**

Please send a copy of my child's immunization record to her/his doctor at the following address:

Doctor's Name _____ Mailing Address _____ City _____ State _____ Zip _____

Health Dept only:

Date	Item Code	Cost Type	Lot number	Vaccine Administration site	Provider #
	FLU-PFA (Single dose) FLU – SP (MULTI dose)	VFC Chargeable		RA LA	
	Flu Must	VFC Chargeable		NASAL	

Nurses Signature and Date: _____

Revised 9-19-2014