2015-2016 STUDENT FLU VACCINATION CONSENT FORM

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Return form to school by September 11, 2015

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

Childs Name: _____ Date of Birth_____ Age:____ Gender: ❑ M ❑ F
Last First Middle

Parents/Guardian's Name:_____ 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: _____

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").** The nurse giving the vaccine will review this information on the day of the vaccine clinic.

		YES	NO
1.	Has your child ever had a serious allergic reaction to any component of any flu vaccine (**eggs, gentamicin, gelatin, and arginine)?**	❑	❑
2.	Has your child ever had a serious reaction to a previous dose of flu vaccine in the past?	❑	❑
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. If you answered *NO* to questions 1, 2 or 3, please continue below.

		YES	NO
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 2015, 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, 2015. **Your child will require 2 doses this year.**

I have read the 2015 Vaccination Information Statement (VIS) for the (Flu Shot) and 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 _____ **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.

***Note**: Vaccines will be provided to your child without cost to you if your child is eligible for the Vaccines for Children Program. If your child is covered by a private health insurance plan, the Department is required by law to seek reimbursement for all allowable costs associated with the provision of the vaccine.

Insurance*: Please answer the following: This information is required for federal funding purposes for VFC vaccines.

***Name of Insured/Policy Holder*_____ *Relationship of policy holder*_____**
***Insurance group #*_____*D.O.B. of Policy Holder* _____**

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 policy #: _____ ( ) has FAMIS – FAMIS policy #: _____

( ) has Anthem – Anthem policy #_____

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

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

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

____ Anthem HealthKeepers ____ Optima Family Care ____ Virginia Premier ____ Coventry Care _____ 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 _____ Date:_____

***Please send a copy of the front & back of insurance card or provide the following information:**
***Insurance company phone number:**_____ **Insurance company address:**_____

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 (MULI dose)	VFC Chargeable		RA LA	
	Flu Must	VFC Chargeable		NASAL	

Nurses Signature and Date:_____ Revised 8-25-2015