Clinic Date(s): 10/2/2014 Due Date: 9/25/2014

Make your child a HEALTH HERO!

Trussville City Schools

For the health of all of our students, faculty, and your family, we encourage you to obtain a flu vaccination for your child with their local healthcare provider or pediatrician.

HNH Immunizations Inc. is an Alabama based Vaccine for Children Provider that, along with the Family Health Clinic of Union Springs and the support of Alabama based schools of nursing, will be offering the **pain-free FluMist® Quadrivalent vaccine** for our students with no deductibles or out of pocket expenses. Medicaid, BCBS, ALL Kids, and other private insurance companies will be billed. Students with no insurance will be provided their flu vaccine at no cost, while supplies last. **If you prefer an IIV (shot) please contact 1-205-609-0268, and IIV forms and Vaccine Information Statements will be sent to you for completion.**

PEEHIP members and dependents are required to participate in the ADPH Wellness clinics for any onsite vaccinations. We are prohibited from vaccinating PEEHIP members and dependents.

The Health Hero Clinic is **voluntary**. If you wish to participate in this convenient clinic to help keep your child and our schools healthy, you must **complete both sides of this form in full.** Please use black or blue ink.

Student Information

First Name:	Middle Initial:	Last Name:

Student Date of Birth: (MM/DD/YY)	Age:	Gender: Male Female	Name of School:	Homeroom Teacher:	Grade:

Student Race: Please Circle	White	African American	American Indian	Hispanic	Asian	Other

Authorizing Parent or Guardian Information

First Name:	Last Name:	Relationship:

Address:	City:	Zip:

Cell or Emergency Contact Number:	Child's Primary Physician:

Required Insurance Information

BCBS	All Kids	Medicaid	TriCare	Uninsured *It is considered fraud to administer VFC vaccine to an insured child	Underinsured *Insurance coverage but does not cover vaccine *Insurance only covers select vaccines *Insurance caps vaccine coverage	Other: Please write in the insurance company name.

Cardholder Name:	Cardholder Date of Birth: (MM/DD/YY)	Contract or Member ID: Include prefix example PPA,IBU, etc.

Please complete the medical history questions on the reverse side.
Vaccinations cannot be given without parent's or guardian's signature.

HNH Immunizations Inc., 326 Prairie St. North, Union Springs, AL 36089, 205-609-0268

Vaccination & Health Related Questions

1.	Is this the first time this child will be vaccinated for the flu?	YES	NO
2.	Was this child vaccinated for the first time last year? If yes, how many doses?	YES	NO
3.	Does this child have Asthma? If yes, date of last treatment?	YES	NO
4.	Has this child ever had a severe or life threatening allergic reaction to the flu vaccine?	YES	NO
5.	Does this child have any of the following:	YES	NO
	Diabetes or other metabolic disorders	YES	NO
	Heart disease or disorders	YES	NO
	Kidney disease or disorders	YES	NO
	Blood disease or disorders	YES	NO
6.	Is this child allergic to vaccine components such as: eggs, gentamicin sulfate, or MSG?	YES	NO
7.	Is this child pregnant or nursing?	YES	NO
8.	Has this child ever had Guillain-Barre syndrome?	YES	NO
9.	Is this child on long term aspirin therapy?	YES	NO
10.	Does this child take medications that lower the body's resistance to infection?	YES	NO
11.	Does this child live with or expect to have close contact with a person whose immune system is **severely** compromised and must be in a protective isolation environment? (e.g. an isolation room of a bone marrow transplant unit)	YES	NO
12.	Has this child received any other vaccinations in the past 4 weeks? If yes, what vaccination(s)?	YES	NO

Authorization for the Administration of the Influenza Vaccine for

_____

Student's Name

I am aware that the receiver of this vaccine is currently not pregnant and should not become pregnant within four weeks of receiving this vaccine. I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information on www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the student/child above of whom I am the parent or legal guardian and acknowledge no guarantees have been made concerning the vaccines success. I hereby release Trussville City Schools, HNH Immunizations Inc., the Family Health Clinic of Union Springs, affiliated schools of nursing, their directors, or employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date.

_____ _____

Signature of Parent or Guardian **Date**

For Administrative Use Only

Clinic Location:	Date:
Vaccine Lot & Expiration Date:	
RPh:	RN:
VIS CDC LAIV 7-26-2013	0.2mL Intranasal

Cash	Check
DB:	
Filed:	
PDF:	
Other:	