2018 School Based Influenza Vaccine Consent Form

Bartow County Health Department

Georgia Department of Public Health

OFFICE USE ONLY: PATIENT NUMBER

Information about Student to Receive Influenza Vaccine (please print)

SCHOOL NAME:		TEACHER (Homeroom):	GRADE:
STUDENT NAME (Last)	(First)	(Middle)	
STUDENT'S DATE OF BIRTH (mm/dd/yyyy)	STUDENT'S AGE	GENDER: (Please Circle) Male / Female	PARENT/ LEGAL GUARDIAN'S NAME
HOME ADDRESS			PARENTAL/ GUARDIAN PHONE NUMBER(S)
CITY STATE		ZIP CODE	EMAIL:

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 Islander, Other

Please provide the insurance information & *attach a copy of the insurance card to this form if possible.*

Policy Holder Name_____

Policy Holder DOB_____

Group#_____

Member ID #_____

INSURANCE INFORMATION: Please check health insurance provider below:

Private
- ☐ Aetna
- ☐ Blue Cross Blue Shield
- ☐ Cigna
- ☐ United Healthcare

State Supplied
- ☐ Medicaid
- ☐ Wellcare
- ☐ Amerigroup
- ☐ PeachState
- ☐ CareSource
- ☐ No Insurance

Medical Information: *The following questions will help us to determine if this student can receive the influenza vaccine. Check school website for the date we will be at your student's school. Please circle Yes or No for each question.*

1. How much does your child weigh? ⟶	_____ lbs.	
2. Has the student ever had a serious reaction to eggs? *(Student cannot get a flu shot if the answer is Yes)	* Yes	No
3. Has the student ever had a serious reaction to any influenza vaccine or vaccine component? *(Student cannot get a flu shot if the answer is Yes)	* Yes	No
4. Has the student ever had Guillain-Barre Syndrome (GBS)? (*A disease that causes paralysis*) *(Student cannot get a flu shot if the answer is Yes)	* Yes	No
5. Is the student on long term aspirin or aspirin-containing therapy? (*For example: does the student take aspirin everyday.)*	Yes	No
6. 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, HIV, cancer or a weakened immune system.)*	Yes	No
7. For female student only, is the student pregnant?	Yes	No

I GIVE CONSENT *to the Bartow County Health Department 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 08/07/15 Vaccine Information Statement for the influenza vaccine. The Notice of Privacy Policy Form is available. I have had a chance to ask questions which were answered to my satisfaction. Questions call 770-607-6241 or 770-383-7375. 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 injectable influenza vaccine.

Signature of Parent/Legal Guardian: _____ ***Date:*** _____

FOR CLINIC USE ONLY

VIS Date (Listed Below)	Mfg, Lot# & Expiration Date: (Place Appropriate Sticker Below)	Inactivated Influenza Vaccine Quadrivalent (IIV_4) Adm Route: IM	Date Entered into M&M:		Entry Clerk's Initial:
8/7/15	*Place Sticker HERE*	(*Circle Site*) **Right Deltoid** **Left Deltoid**	**Signature of Nurse:**		
			Date:		