Georgia Department of Public Health

2021-2022 School Based Influenza Vaccine Consent Form

Richmond County Health Department

Section 1: Information about Student to Receive Influenza Vaccine (please print)

STUDENT'S NAME (Last)	(First)	(M.I.)	SCHOOL NAME:	
STUDENT'S DATE OF BIRTH (mm/dd/yyyy)	STUDENT'S AGE	GENDER: M / F	TEACHER	GRADE
ETHNICITY *(Please Circle)* Not Hispanic/Latino Hispanic Latino	RACE *(Please Circle)* African American, White, American Indian, Asian, Alaska Native, Native Hawaiian, Other Pacific Islander, Other		PARENT/ LEGAL GUARDIAN'S NAME	
HOME ADDRESS			PARENTAL/ GUARDIAN PHONE NUMBER(S)	
CITY STATE		ZIP CODE	PARENTAL/ GUARDIAN E-MAIL	

INSURANCE INFORMATION: Do you have Insurance that covers vaccines? ☐Yes / ☐No

Please check health insurance provider below:

☐ Aetna ☐ Medicaid ☐ No Insurance
☐ Blue Cross Blue Shield ☐ PeachCare ☐ Other_____
☐ Cigna ☐ United Healthcare

Provide the insurance information for the provider selected & *attach a copy of the insurance card to this form*

Policy Holder Name_____

Group#_____

Member ID #_____

Section 2: Medical Information: *The following questions will help us to determine if this student can receive the influenza vaccine.*

***Please circle Yes or No for each question.**

1.	Has the student received any vaccines in the last four weeks? If yes, please list:	Yes	No
2.	When was the student last vaccinated for flu?	**DATE:**	
3.	Has the student ever had a serious reaction to eggs?	Yes	No
4.	Has the student ever had a serious reaction to any influenza vaccine?	Yes	No
5.	Does the student use an inhaler or receive breathing treatments for asthma or a wheezing condition?	Yes	No
6.	Is the student on long term aspirin or aspirin-containing therapy (For example: does the student take aspirin everyday)	Yes	No
7.	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)	Yes	No
8.	Is the student to be vaccinated receiving influenza antiviral medications?	Yes	No
9.	Does the student have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	Yes	No
10.	Is the student or could the student be pregnant?	Yes	No
11.	Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No

Section 3: Consent: *The vaccine consent form allows you to accept the vaccination for your child. If this consent form is not filled in completely, signed, dated, and returned, the student will not be vaccinated at school.*

☐ **I GIVE CONSENT** to the Ricmond County Health Departmnent ***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 Vaccine Information Statements for the influenza vaccines and the NOTICE of PRIVACY POLICY FORM. I have had a chance to ask questions which were answered to my satisfaction. 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:*** _____

DO NOT RETURN FORM TO SCHOOL IF YOU DO NOT WANT YOUR CHILD TO RECEIVE A FLU VACCINATION

FOR CLINIC USE ONLY

Influenza Vaccine:	Adm Route	Date Dose Administered:	Mfg:	Lot #	Exp Date:	VIS Date:	
☐ Inactivated Influenza Vaccine - Quadrivalent (IIV_4)	**IM:** LA / RA	/ /			/ /	/ /	Signature of Nurse: _____ Date: _____

Entry Clerk Initial: _____ Date: _____