2018-19 School Based Influenza Vaccine Consent Form

** Richmond County Health Department**

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

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| 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 All That Apply)*** African American, White, American Indian, Asian, Alaska Native, Hawaiian/Polynesian Islander, OtherRACE | 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 |
| 1. When was the student last vaccinated for flu?
 | **DATE:** |
| 1. Has the student ever had a serious reaction to eggs?
 | Yes | No |
| 1. Has the student ever had a serious reaction to any influenza vaccine?
 | Yes | No |
| 1. Is the student on long term aspirin or aspirin-containing therapy (For example: does the student take aspirin everyday)
 | Yes  | No |
| 1. Does the student have any significant or chronic (long term) health conditions? **If YES, please explain.**
 | Yes | No |
| 1. Is the person to be vaccinated receiving influenza antiviral medications?
 | Yes | No |
| 1. 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 |
| 1. Is the student or could the student be pregnant?
 | Yes | No |
| 1. Has the student ever had Guillain-Barre Syndrome (GBS)?
 | Yes | No |

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

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| --- |
|  **I GIVE CONSENT** to the **Richmond 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 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **FOR CLINIC USE ONLY** |
| **Inactivated Influenza** **Vaccines (IIV)**[ ]  Quadrivalent (IIV**4**) | **Adm Route: IM**LA / RA | **(IIV)** | **Date Dose Administered:** | **Mfg:** | **Lot #** | **Exp Date:** | **VIS Date:** | **Signature of Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |