Georgia Department of Public Health

2017-2018 School Based Influenza Vaccine Consent Form
Richmond County Health Department - SBF
Must Print Clearly and Fill Out ALL Information

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, Hispanic or Latino, Ame Asian Alaska Native, Native Hawaiian, Other Pacific		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: - Fill in box to right and attach copy of insurance card

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

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 child 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.	Is the person to be vaccinated receiving influenza antiviral medications?	Yes ◯	No ◯
8.	Does the student have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)? **CIRCLE OR LIST HEALTH ISSUE**	Yes ◉	No ◯
9.	Is the student or could the student be pregnant?	Yes ◯	No ◯
10.	Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes ◯	No ◯

Section 3: Consent: *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 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 (flu shot).**

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

If you do not wish for your child to receive the flu immunization - just discard form. Vaccine will be given between October 1, 2017 and January 15, 2018. Please notify the School Nurse if your child receives a vaccine at another location.

FOR CLINIC USE ONLY

Inactivated Influenza Vaccines (IIV)	Adm Route: IM	Date Dose Administered:	Mfg:	Lot #	Exp Date:	VIS Date:	Signature of Nurse: / Date:
☐ Trivalent (IIV_3)	LA / RA	/ /			/ /	/ /	Entry Clerk Initial: / Date:
☐ Quadrivalent (IIV_4)	LA / RA						