



2020-21 SCHOOL BASED INFLUENZA VACCINE CONSENT FORM

SCHOOL NAME _____

If you do NOT want your child to receive flu vaccine at school, please do NOT fill out or return this form.

Section 1: Information About the Student Who Will Receive Influenza Vaccine (please print)

STUDENT'S FIRST NAME		MIDDLE INITIAL	LAST NAME		NICKNAME (Name student goes by):	
DATE OF BIRTH (mm/dd/yyyy)		AGE	GENDER (Please check) Male Female		HOMEROOM TEACHER GRADE	
ETHNICITY (Please Check) Hispanic/Latino <input type="checkbox"/> Yes / <input type="checkbox"/> No		RACE (Please Check): African American/Black, White, American Indian, Asian, Alaska Native, Native Hawaiian, Other Pacific Islander, Other			PARENT/ LEGAL GUARDIAN'S NAME	
HOME ADDRESS					PARENT/ GUARDIAN PHONE NUMBER(S)	
CITY		STATE	ZIP CODE		*Provide insurance plan information below <i>Name of Policy Holder/Name on ID Card:</i> _____ <i>Member ID#:</i> _____ <i>Group#/Policy Type (HMO, PPO, CMO):</i> _____ <i>Please attach a copy of the insurance card to this form</i>	
INSURANCE INFORMATION: Does your child have Insurance that covers vaccines? <input type="checkbox"/> Yes / <input type="checkbox"/> No If "Yes," please check health insurance provider below & complete the information to the right*:						
<input type="checkbox"/> Aetna	<input type="checkbox"/> Medicaid/Amerigroup/Peachstate/Wellcare/CareSource	<input type="checkbox"/> No Insurance				
<input type="checkbox"/> Blue Cross/Blue Shield	<input type="checkbox"/> Peachcare for Kids					
<input type="checkbox"/> Cigna	<input type="checkbox"/> United Healthcare					
<input type="checkbox"/> Coventry	<input type="checkbox"/> Other _____					

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

**Please check Yes or No for every question.*

1. When was the student last vaccinated for flu (if known)?	DATE:	
2. Has the student ever had a serious allergic reaction to eggs?	YES	NO
3. Has the student ever had a serious reaction to any influenza (flu) vaccine?	YES	NO
4. Has the student ever had Guillain-Barre Syndrome (GBS)?	YES	NO

Section 3: Consent to vaccinate:

If this consent form is not filled out completely, signed, dated, and returned, the student will not be vaccinated at school.

CONSENT FOR STUDENT TO RECEIVE INFLUENZA VACCINE

By signing below, I acknowledge that the student and medical information provided above is correct. I have received a copy of the VACCINE INFORMATION STATEMENT for INFLUENZA VACCINE and the NOTICE of PRIVACY POLICY FORM. I was given the opportunity 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 above. I understand that participation and receipt of the influenza vaccine through this program is completely voluntary.

By signing below, I give consent for the student listed above to receive flu vaccine at school.

Signature of Parent/Legal Guardian: _____ Date: _____

FOR CLINIC USE ONLY

VIS: Inactivated Influenza Vaccine 8/15/2019 LD RD Mfg: _____ Lot # _____ Exp Date: _____	_____ NURSE SIGNATURE _____ DATE
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Demographic/Insurance information entered/updated by: _____ Date: _____

PUBLIC	\$PRIVATE\$	PIN#:
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