Healthy Schools

2017-2018 Seasonal Flu Shot (IIV) Vaccine Consent Form

Full, Legal Name of Student (*First Name Middle Initial. Last Name*) PLEASE PRINT		**Name of School**	
Parent/Guardian Name (*First Name Middle Initial. Last Name*)	**Relationship to Student**	**Homeroom Teacher / Grade**	
Address	**Email Address**	**Birth Date** (month / date / year)	**Age** **Sex**
City	**Zip Code**	**Home Phone #**	**Cell Phone #**

Demographic Information: (Circle one) :White American Indian/ Native Alaskan Black Asian Hispanic Other

---

IF YOU DO NOT WISH TO PARTICIPATE PLEASE CHECK HERE: NO ☐

if you do not wish to participate you do not have to complete the rest of the form

Insurance ☐ **Medicaid** ☐ **Circle 1 & or Write: (Ex: AmeriGroup, Wellcare, Integral, Prestige, Humana, Sunshine, BetterHealth) Please fill out the following questions**	
Insurance Company:	**Member ID:**
Policy Holder's Name:	**Policy Holder's Date of Birth:**
The current health care laws require us to bill your insurance company for the vaccine. You will not be billed, and there will be no co-pay or deductible due. The service is offered at no cost to you! As always, answers are confidential!	☐ **MY CHILD DOES NOT HAVE HEALTH INS**

QUESTIONS: CHECK YES OR NO FOR **EACH** QUESTION

Yes ☐ No ☐ 1.) **Is your child 4 years or older?**

Yes ☐ No ☐ 2.) **Do any of the following apply to your child?** ***(If you answer YES, your child cannot receive a Flu Vaccine at school-, please contact your child's doctor)***

- **Allergy to chicken eggs or egg products**
- **Life threatening reaction(s) to flu vaccine in the past**
- **Allergy to Latex**
- **Has had Guillain-Barre syndrome (very rare)**

Yes ☐ No ☐ 3.) **Do any of the below apply to your child?**

- **Has long-term health problems with weakened immune system, heart disease, lung disease (e.g. cystic fibrosis), liver disease, kidney disease, or metabolic disorders (e.g. diabetes) or blood disorders (e.g. sickle disease or thalassemia)**

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL HEALTHY SCHOOLS AT 1800-566-0596 TO SPEAK TO A NURSE.

I have received, read, and understand the CDC Vaccine Information Statement for the Inactivated Influenza Vaccine (IIV). I have read these documents and understand the risk and benefits of the IIV vaccine. I give permission to Healthy Schools and their administrators to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Florida Department of Health policies, to assure optimal healthcare for my child. . I hereby release Healthy Schools from any and all liability associated with the administration and potential side effects of the vaccine.

☐ **YES, I Want To Help Protect My Family And Community From Flu By Allowing My Child To Receive a Flu SHOT!**

Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

VIS CDC IIV _____ **LOT Number:**	IIVt0.5L IM Injection **EXP Date:**	VIS CDC IIV _____ **LOT Number:**	IIV 0.5 mL IM Injection **EXP Date:**
RN #_____ Date:_____	**(RUA) OR (LUA) (Circle One)**	RN # _____ Date: _____	**RUA) OR (LUA) (Circle One**