



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

Full, Legal Name of Student <i>(First Name Middle Initial. Last Name)</i> PLEASE PRINT		Name of School		
Parent/Guardian Name <i>(First Name Middle Initial. Last Name)</i>		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 <input type="checkbox"/> Medicaid <input type="checkbox"/> 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. <u>You will not be billed</u> , and there will be no co-pay or deductible due. There will be no out of pocket expense for the services provided!	
<input type="checkbox"/> MY CHILD DOES NOT HAVE HEALTH INS	

QUESTIONS: CHECK YES OR NO FOR EACH QUESTION

Yes <input type="checkbox"/>	No <input type="checkbox"/>	1.) <u>Is your child 4 years or older?</u>
Yes <input type="checkbox"/>	No <input type="checkbox"/>	2.) Do any of the following apply to your child? <i>(If you answer YES, your child cannot receive a Flu Vaccine at school-, please contact your child's doctor)</i> <ul style="list-style-type: none"> • 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 <input type="checkbox"/>	No <input type="checkbox"/>	3.) Do any of the below apply to your child? <ul style="list-style-type: none"> • 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)