

2023-24 School Based Influenza Vaccine Consent Form School Name

VHN N	umber:	
	aiiibei.	

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

STUDENT'S FIRST NAME	MIDDLE INITIAL	MIDDLE INITIAL		NICKNAME (Name student goes by a	at school)		
DATE OF BIRTH (mm/dd/yyyy)	AGE	GENDE Male	R (<i>Please check)</i> Female	HOMEROOM TEACHER	GRADE		
ETHNICITY (Please Check) Hispanic/Latino Yes No RACE (Please Check): African American/Black White Hispanic or Latino American Indian Asian Alaska Native Native Hawaiian Other Pacific Islander Other				PARENT/ LEGAL GUARDIAN'S NAME			
HOME ADDRESS				PARENT/ GUARDIAN PHONE NUM	BER(S)		
CITY STATE			ZIP CODE	Name of Policy Holder/Name on	*Provide insurance plan information below Name of Policy Holder/Name on ID Card:		
INSURANCE INFORMATION: <u>Does you</u> If "Yes," please check health insurance							
Aetna M	Member ID#:						
Ambetter	nited Healthcare MR	No Insuran	Group#/Policy Type (HMO, P		PO, CMO):		
•	RICARE Standard ONLY reSource Marketplace	Other		Please attach a copy of the insurance	Please attach a copy of the insurance card to this form		
Section 2: Medical Information:	The following ques	tions will help (us to determine if th	his student can receive the influent	za vaccine.		

	Please theth res of No joi	e cneck yes or No Jor every 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 or Year			
3.	Has the student ever had a serious allergic reaction to eggs?	Yes	No	
4.	Has the student ever had a serious reaction to any influenza (flu) 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)			
7.	Does the student have any significant or chronic (long term) health conditions? (For example: diabetes, sickle cell disease, heart condition, lung condition, seizure disorder, cerebral palsy, muscle or nerve disorder, juvenile arthritis)			
8.	Does the student have a weak immune system?	Yes	No	
	(For example, from HIV, cancer, or from taking medications such as steroids or those used to treat cancer?)			
9.	Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No	
10.	Adolescent females only: Is the student pregnant?	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 been given a copy of the VACCINE INFORMATION STATEMENT for INFLUENZA VACCINE. 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. I understand that it is my responsibility to notify the school and the participating health department at least three business days prior to the school-based flu vaccination clinic event if my child has already received a flu vaccine by another provider this year. By signing below, I give permission for the student listed above to receive flu vaccine. Signature of Parent/Legal Guardian: _ FOR CLINIC USE ONLY Intranasal Influenza Vaccine 2023-24 Inactivated Influenza Vaccine 2023-24 Administration Route: IM / LEFT Deltoid IM / RIGHT Deltoid Vaccine Code: Vaccine Code: Lot # _____ Lot # Exp Date: ____ Exp Date: _____ Vaccine Administration Date _____ Vaccine Administration Date: Date: __ Entry Clerk Initial: ___