

School Name _____

If you do NOT want your child to receive flu vaccine, do NOT fill out or return 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 at school)	
DATE OF BIRTH (mm/dd/yyyy)		AGE	GENDER (Please check) Male 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 NUMBER(S)		
CITY		STATE		ZIP CODE		*Provide insurance plan information below.
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*:						Name of Policy Holder/Name on ID Card: _____
Aetna		Medicaid/PeachCare/Amerigroup/Peachstate/CareSource		Member ID#: _____		
Ambetter		United Healthcare		Group#/Policy Type (HMO, PPO, CMO): _____		
Anthem BCBS		UMR		_____		
Cigna		TRICARE Standard ONLY		No Insurance		
		CareSource Marketplace		Other		
						Please attach a copy of the insurance card to this form.

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. 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 every day)	Yes	No
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)	Yes	No
8. Does the student have a weak immune system? (For example, from HIV, cancer, or from taking medications such as steroids or those used to treat cancer?)	Yes	No
9. Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No
10. Adolescent females only: Is the student pregnant?	Yes	No
11. Is the person to be vaccinated receiving influenza antiviral medications?	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 (VIS) for INFLUENZA VACCINE or a QR code to view the VIS 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: _____ Date: _____

FOR CLINIC USE ONLY

Inactivated Influenza Vaccine 2025-26
Administration Route: IM / LEFT Deltoid IM / RIGHT Deltoid
Vaccine Code: _____
Lot # _____
Exp Date: _____
Vaccine Administration Date _____

Intranasal Influenza Vaccine 2025-26
Administration Route: Intranasal
Vaccine Code: _____
Lot # _____
Exp Date: _____
Vaccine Administration Date: _____



English
Influenza (Flu) Vaccine
Vaccine Information Statement

Nurse Signature: _____ Date: _____ Entry Clerk Initial: _____ Date: _____

PUBLIC \$PRIVATE\$