2016-2017 Seasonal Flu Vaccine Consent Form

Please complete the entire form and sign! Incomplete forms will not be accepted

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

Insurance ☐ Medicaid/CHIP ☐ Please write Medicaid/ Insurance Below	Please fill out the following questions concerning your child's insurance
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 yes, your child cannot receive the Flu Vaccine (IIV) at School. Please consult your child's doctor

- Allergy to eggs
- Life threatening reaction to this vaccine in the past
- 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 IIV Flu Shot. I have read these documents and understand the risk and benefits of the Flu vaccine. I have reviewed the Notice of Privacy Practices of Healthy Schools, LLC or will review the Notice on the day the vaccination is administered. I give permission to Healthy Schools, E3 Alliance, and Schoolhouse Pediatrics 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 Texas Department of Health policies, to assure optimal healthcare for my child. I hereby release Healthy Schools, E3 Alliance and Schoolhouse Pediatrics 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 Vaccine!

☐ NO, I Do Not wish for my child to participate (reason)________________________________

______________________ ______________________ ______________________
Printed Name of Parent/Guardian Signature of Parent/Guardian Date Signed/ Date VIS Provided

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION
Healthy Schools LLC, 818 Highway A1A North, Ponte Vedra Beach Florida

VIS CDC LAIV: IIV Flu Vaccine 0.5ML IIV (Sequiris/Sanofi)	VIS CDC LAIV: IIV Flu Vaccine 0.5ML IIV (Sequiris/ Sanofi)
LOT Number:____________ EXP Date:____________	LOT Number:____________ EXP Date:____________
School Name____________________	School Name____________________
RN Name/Title________________Date:__________	RN Name/Title________________Date: __________