2019-2020 School Based Influenza Vaccine Consent Form
HEARD COUNTY HEALTH DEPARTMENT

Georgia Department of Public Health
District 4 Public Health

STUDENT'S NAME (Last)	(First)		(M.I.)	SCHOOL NAME:
STUDENT'S DATE OF BIRTH (MM/DD/YYYY)	STUDENT'S AGE:	GENDER:	TEACHER:	
ETHNICITY:(Please Circle) NOT Hispanic or Latino Hispanic or Latino Other _____	RACE (Please Circle): African American, White, American Indian, Asian, Alaska Native, Native Hawaiian, Pacific Islander, Other		GRADE:	PARENT/LEGAL GUARDIAN'S NAME:
HOME ADDRESS:			PHONE NUMBER:	
CITY:	STATE:	ZIP: EMAIL:		

INSURANCE INFORMATION: Do you have insurance that covers vaccines? ⬭ Yes ⬭ No	Please **check** health insurance provider: ____Aetna _____ Medicaid ____Cigna ____ Peach Care ____United Healthcare ____ Anthem/BCBS ____ Other _____ _____No Insurance	Provide the insurance information for the provider selected & attach a copy of card to this form if possible Policy Holder Name: _____ Member ID #: _____ Group #: _____

Section 1: Medical Information: Please circle Yes or No for each 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 influenza? Date:		
3. Has the student ever had a serious reaction to eggs?	Yes	No
4. Has the student ever had a serious reaction to any influenza vaccine?	Yes	No
5. Does the child use an inhaler or receive breathing treatments for asthma or wheezing?	Yes	No
6. Is the student on long term aspirin or aspirin-containing therapy?	Yes	No
7. Does the student have any significant or chronic long-term health conditions? Ex. Diabetes, Sickle Cell Disease, heart conditions, lung conditions, seizure disorders, Cerebral Palsy, muscle or nerve disorders	Yes	No
8. Is the student currently receiving influenza antiviral medications?	Yes	No
9. Does the student have a weak immune system from HIV, Cancer, or medications such as steroids or those? used to treat Cancer?	Yes	No
10. Is the student (or could the student) be pregnant?	Yes	No
11. Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No

Section 2: Consent: If this consent in not filled out, signed and dated, the student will not be vaccinated at school.

☐ **I GIVE CONSENT** to the **Heard County Health Department** *for the student named above the injectable influenza vaccine.* 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 the influenza vaccine. I have had 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. By signing below, I give permission for the student listed above to receive the **injectable** influenza vaccine.

Signature of Parent/Legal Guardian: _____ ***Date:*** _____

FOR CLINIC USE ONLY

Inactivated Influenza (IM) Location	Date Dose Administered:	Mfg.:	Lot #:	Exp Date:	VIS Date:	Signature of Nurse
Lt Deltoid Rt Deltoid						