Georgia Department of Public Health
Effingham County Health Department

2019-20 School Based Influenza Vaccine Consent Form

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):	
DATE OF BIRTH (mm/dd/yyyy)	AGE	GENDER (*Please circle*) Male Female	HOMEROOM TEACHER	GRADE
ETHNICITY (*Please Check*) Hispanic/Latino ☐ Yes / ☐ No	RACE (*Please Circle*): 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 *Name of Policy Holder/Name on ID Card:* _____ *Member ID#:* _____ *Group#/Policy Type (HMO, PPO, CMO):* _____ Please *attach a copy of the insurance card to this form*	

INSURANCE INFORMATION: Does your child have Insurance that covers vaccines? ☐ Yes / ☐ No

If "Yes," please check health insurance provider below & complete the information to the right*:

- ☐ Aetna
- ☐ Ambetter
- ☐ Blue Cross Blue Shield
- ☐ Cigna
- ☐ Coventry
- ☐ Medicaid/Amerigroup/Peachstate/Wellcare/CareSource
- ☐ Peachcare for Kids
- ☐ United Healthcare
- ☐ TRICARE Standard ONLY
- ☐ Other_____
- ☐ No Insurance

Section 2: Medical Information: The following questions will help us to determine if this student can receive the influenza vaccine.

**Please circle 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 everyday)	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

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.

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

Intranasal Influenza Vaccine 2019-20	Inactivated Influenza Vaccine 2019-20
Administration Route: ☐ Intranasal	**Administration Route:** ☐ IM / LEFT Deltoid ☐ IM / RIGHT Deltoid
Mfg: _____	Mfg: _____
Lot # _____	Lot # _____
Exp Date: _____	Exp Date: _____

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

PUBLIC $PRIVATE$

PIN#: