Georgia Department of Public Health

2014-15 School Based Influenza Vaccine Consent Form
COFFEE COUNTY HEALTH DEPARTMENT

Section 1: Information About Student to Receive Influenza Vaccine (please print)

STUDENT'S NAME (Last)	(First)	(Middle Initial)	SCHOOL NAME:	
DATE OF BIRTH (mm/dd/yyyy)	STUDENT'S AGE	GENDER (*Please circle*) Male Female	TEACHER	GRADE
ETHNICITY *(Please Circle)* Not Hispanic/Latino Hispanic	RACE *(Please Circle)* African American, 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	PARENT/ GUARDIAN E-MAIL	

INSURANCE INFORMATION: Do you have Insurance that covers vaccines? ☐Yes / ☐No

Please check health insurance provider below:

☐ Aetna ☐Medicaid ☐No Insurance
☐ Blue Cross Blue Shield ☐Peachcare
☐ Other_____

Provide the insurance information for the provider selected. *Attach a copy of the insurance card to this form*

Policy Holder Name_____
Group#_____
Member ID #_____

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 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 flu (if known)?	**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 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 disorders)	Yes	No
8.	Does the student have a weak immune system? (For example: from HIV, cancer, or medications such as steroids or those used to treat arthritis or cancer)	Yes	No
9.	Is the student or could the student be pregnant?	Yes	No
10.	Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No

Section 3: Consent to vaccinate:

If this consent form is not filled in completely, signed, dated, and returned, the student will not be vaccinated at school.

CONSENT FOR STUDENT TO RECEIVE INFLUENZA VACCINE:

By signing below, I give permission for the student named above to receive the influenza vaccine. I acknowledge that the student and medical information provided above is correct. I have been given a copy of the Vaccine Information Statements for the influenza vaccines and the NOTICE of PRIVACY POLICY FORM. 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 the intranasal or injectable influenza vaccine.

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

FOR CLINIC USE ONLY

FluMist Influenza Vaccine 2014-2015 VIS 08-19-2014	**Inactivated Influenza Vaccine 2014-2015 VIS 08-19-2014**
Administration Route: ☐ Intranasal	Administration Route: ☐ IM / LD ☐ IM / RD
Mfg: _____	Mfg: _____
Lot # _____	Lot # _____
Exp Date: _____	Exp Date: _____
Nurse Signature: _____ Date: _____	**Nurse Signature:** _____ Date: _____
Entry Clerk Initial: _____ Date: _____	Entry Clerk Initial: _____ Date: _____

PUBLIC/VFC **$PRIVATE/CP$**