Georgia Department of Public Health
Southeast Health District

2018-19 School Based Influenza Vaccine Consent Form
COFFEE COUNTY HEALTH DEPARTMENT

Section 1: Information About the Student Who Will Receive Influenza Vaccine (please print)

STUDENT'S FIRST NAME	MIDDLE INITIAL	(LAST NAME)	SCHOOL NAME:	
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 ☐ Medicaid/Amerigroup/Peachstate/Wellcare/CareSource
☐ Blue Cross Blue Shield ☐ Peachcare for Kids
☐ Cigna ☐ United Healthcare ☐ No Insurance
☐ Coventry ☐ Other_____

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. Is the person to be vaccinated receiving influenza antiviral medications?	Yes	No
9. 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
10. Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No
11. 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 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 injectable ("flu shot") or intranasal influenza vaccine (FluMist®).

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

FOR CLINIC USE ONLY

Intranasal Influenza Vaccine 2018-19 VIS 08-07-2015	Inactivated Influenza Vaccine 2018-19 VIS 08-07-2015
Administration Route: ☐ **Intranasal**	**Administration Route:** ☐ **IM / LEFT Deltoid** ☐ **IM / RIGHT Deltoid**
Mfg: _____	Mfg: _____
Lot # _____	Lot # _____
Exp Date: _____	Exp Date: _____

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

PUBLIC **$PRIVATE$** **PIN#:**