Georgia Department of Public Health
Coastal Health District

# 2021-22 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
- ☐ BCBS/ANTHEM
- ☐ Cigna
- ☐ Medicaid/Amerigroup/Peachstate/Wellcare/CareSource
- ☐ Peachcare for Kids
- ☐ United Healthcare
- ☐ UMR
- ☐ 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**

| Inactivated Influenza Vaccine 2021-22 | Intranasal Influenza Vaccine 2021-22 |
|---|---|
| Administration Route: ☐ IM / LEFT Deltoid ☐ IM / RIGHT Deltoid | Administration Route: ☐ Intranasal |
| VHN Code: _____ | VHN Code: _____ |
| Lot # _____ | Lot # _____ |
| Exp Date: _____ | Exp Date: _____ |

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

**PUBLIC $PRIVATE$**

**VHN Number:**