Georgia Department of Public Health
Bryan County Health Department

# 2018-19 School Based Influenza Vaccine Consent Form

**School Name _____**

## Section 1: Information about Student to Receive Influenza Vaccine (please print clearly)

| | | | | | |
|---|---|---|---|---|---|
| STUDENT'S NAME (Last) | (First) | (M.I.) | (Nickname) | | |
| STUDENT'S DATE OF BIRTH (mm/dd/yyyy) | | STUDENT'S AGE | GENDER: M / F | TEACHER | GRADE |
| ETHNICITY *(Please Circle)*<br>Not Hispanic/Latino Hispanic/Latino | | RACE *(Please Circle)*<br>African American, Caucasian, Hispanic/Latino, American Indian, Asian, Alaska Native, Native Hawaiian, Pacific Islander, Other | | PARENT/ LEGAL GUARDIAN'S NAME | |
| HOME ADDRESS | | | | PARENTAL/ GUARDIAN PHONE NUMBER(S) | |
| CITY STATE | | ZIP CODE | | PARENTAL/ GUARDIAN E-MAIL | |
| **INSURANCE INFORMATION: Do you have Insurance that covers vaccines?** ☐Yes / ☐No<br>**Please check health insurance provider below:**<br>☐Medicaid ☐Aetna ☐TRICARE Standard **ONLY**<br>☐Peachcare ☐Cigna ☐Other_____<br>☐Blue Cross Blue Shield ☐United Healthcare ☐No Insurance | | | | **Provide the insurance information for the provider selected & *attach a copy of the insurance card to this form***<br>Policy Holder Name_____<br>Group#_____<br>Member ID #_____ | |

## Section 2: Medical Information

| | | | |
|---|---|---|---|
| 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:** | |
| 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. | Is the student on long term aspirin or aspirin-containing therapy (For example: does the student take aspirin everyday) | Yes | No |
| 6. | Does the student have any significant or chronic (long term) health conditions? (For example: diabetes, sickle cell disease, heart conditions, lung conditions, seizure disorders, cerebral palsy, muscle or nerve disorders) | Yes | No |
| 7. | Does the student have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)? | Yes | No |
| 8. | Is the student or could the student be pregnant? | Yes | No |
| 9. | Has the student ever had Guillain-Barre Syndrome (GBS)? | Yes | No |

## Section 3: Consent:

***If this consent form is not filled in completely, signed, dated, and returned, the student will not be vaccinated at school.***
If you do not wish for your student to receive the flu vaccine at school, do not sign or return this form.**

☐ **I GIVE CONSENT for the student named above to receive the injectable flu vaccine at the school location from the COUNTY HEALTH DEPARTMENT.** I acknowledge that the student and medical information provided above is correct. I have been given a copy of the Vaccine Information Statement for the 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 the injectable influenza vaccine.

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

### FOR CLINIC USE ONLY

| Inactivated Influenza Vaccines (IIV) | Adm Route: IM | | Date Dose Administered: | Mfg: | Lot # | Exp Date: | VIS Date: | Signature of Nurse: _____ Date: _____ |
|---|---|---|---|---|---|---|---|---|
| ☐ Quadrivalent ($IIV_4$) | LA / RA | | / / | | | / / | / / | Entry Clerk Initial: _____ Date: _____ |