PARENT CONSENT FOR SEASONAL INFLUENZA VACCINATION

FOR CLINIC USE ONLY	School District ID	School Name

STUDENT INFORMATION (use black ink only)

STUDENT FIRST NAME	MI	STUDENT LAST NAME	AGE	GRADE

DATE OF BIRTH(MM/DD/YYYY)	GENDER	SCHOOL	HOMEROOM TEACHER
/ /	☐ MALE ☐ FEMALE		

RACE ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White

ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino

STREET ADDRESS	CITY	STATE	ZIP

PARENT/GUARDIAN FIRST NAME	PARENT/GUARDIAN LAST NAME	PARENT/GUARDIAN CELL TELEPHONE ( ) -

PARENT/GUARDIAN EMAIL ADDRESS	PARENT/GUARDIAN HOME TELEPHONE ( ) -

INSURANCE INFORMATION (fill out completely)

Does your child have SC Medicaid? ☐ NO ☐ YES	If yes, provide your child's SC Medicaid ID number:
Does your child have health insurance? ☐ NO ☐ YES	If yes, does your insurance cover flu vaccine? ☐ NO ☐ YES

INFLUENZA VACCINATION SCREENING QUESTIONS (answer all questions)

	NO	YES
1. Has your child ever had a serious reaction to eggs **OR** a serious reaction to a previous flu vaccine that caused any of the following: wheezing, trouble breathing, hives and itching all over the body, swelling in the mouth or throat, very low blood pressure or shock?	☐	☐
2. Has your child ever had Guillain-Barré Syndrome (a rare type of temporary severe muscle weakness and paralysis)?	☐	☐

If you answered YES to either question 1 or 2, your child cannot receive the 2022-2023 seasonal influenza vaccine at school. Please contact your child's primary healthcare provider.

	NO	YES
3. Has your child received Varicella (Chickenpox), Measles, Mumps and/or Rubella vaccine within the past 30 days? Vaccine Name: _____ Date given:_____	☐	☐
4. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidney, liver, nerves, or blood (including anemia); or have a cochlear implant or spinal fluid leak, or no spleen?	☐	☐
5. Does your child take aspirin or a medication that contains aspirin every day?	☐	☐
6. Does your child have a weak immune system? (for example, treatment for cancer or HIV/AIDS, or taking medications such as steroids that may cause the immune system to be weak)	☐	☐
7. Is your child pregnant? (Please discuss this question with your child for verification)	☐	☐
8. Does your child have close contact with a person who needs care in a protected environment? (For example, someone who is in a bone marrow transplant unit.)	☐	☐
9. If your child is age 2-4 years of age, has your child had a wheezing episode in the past 12 months?	☐	☐
10. Did your child recently receive any of the following antivirals in the specified time frames below: • oseltamivir or zanamivir in the last 48 hours • peramivir in the last 5 days • baloxavir in the last 17 days	☐	☐

If you answered YES to *any* questions 3-10, your child cannot receive the nasal spray flu vaccine. He/she will receive the flu shot.

If you answered NO to questions 3-10, please select the preferred vaccine for your child:
The ***FLU SHOT*** will be given, if no selection is made below.

☐ Flu Shot (Inactivated Influenza Vaccine quadrivalent {IIV4})
☐ Nose/Nasal Spray (Live Attenuated Influenza Vaccine {LAIV})

Please answer if your child is under 9 years old:
Counting all previous flu vaccine doses up until July 1, 2022, has your child received a total of 2 doses? If no or unsure, he/she may need 2 doses of flu vaccine this season.

NO	YES	UNSURE
☐	☐	☐

YOU MUST SIGN ON NEXT PAGE FOR CONSENT TO BE ACCEPTED

AUTHORIZATION AND CONSENT

By signing below, I consent to the use and disclosure of my child's personal health information for public health purposes and program evaluation. DHEC's Privacy Notice can be found at the following link: http://www.scdhec.gov/sites/default/files/Library/ML-025046.pdf or a copy of the notice will be provided upon request.

If applicable, by signing below, I request that payment of Medicaid benefits be made on my behalf to DHEC for any services provided to my child. I give DHEC permission to exchange my child's medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents, or other agents needed to determine benefits related to services provided. I agree to participate in treatment plans and to assignment of Medicaid benefits to DHEC for services rendered.

Vaccine Authorization: I voluntarily request DHEC to provide seasonal influenza vaccine for my child named above, and consent for my child to receive the seasonal influenza vaccine at school, to be administered by DHEC staff. I have read and answered the questions on the previous page carefully and accurately, and I understand that incorrect information could cause serious risks to my child. I understand that the vaccine will be given according to Advisory Committee on Immunization Practices (ACIP) recommendations and the answers I provided to the screening questions 1-10 on the previous page. I have read the Vaccine Information Statement for the flu vaccines: Flu Shot: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf or Nasal spray: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flulive.pdf. I have had an opportunity to ask questions about the vaccine. I understand the risks and benefits of the vaccine. I consent to my child's blood testing by DHEC should there be an occupational exposure during the administration of the influenza vaccine and DHEC deems such testing necessary.

I understand that immunization information about my child will be reported to SC Immunization Registry for public health purposes. I have legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

SIGNATURE OF PARENT OR LEGAL GUARDIAN	**DATE** / /

VACCINATION DETAILS (Influenza V04.81) FOR CLINIC USE ONLY – BLACK INK ONLY

FIRST DOSE

VACCINE ☐ IIV4 ☐ LAIV	**ELIGIBILITY** ☐ VFC MEDICAID ☐ VFC AMERICAN INDIAN/ALASKA NATIVE ☐ VFC UNINSURED (NO INSURANCE) ☐ STATE UNDERINSURED ☐ STATE INSURED		
VIS DATE 08/06/2021	**MANUFACTURER**: ☐ GLAXOSMITHKLINE ☐ ASTRA ZENECA ☐ SANOFI PASTEUR **LOT NUMBER**	**SITE OF ADMINISTRATION** ☐ LD ☐ RD ☐ Nasal ☐ Other_____	
NURSE SIGNATURE	Nurse: I hereby attest by signature below that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consent for vaccination.	**DATE** / /	
		ECODE	**COUNTY CODE**
PATIENT'S/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE	Teacher: I hereby attest by signature below that the identity of the patient in question has been verified.	**DATE** / /	

☐ "What to Know After…" given to student ☐ Unable to vaccinate due to _____ "Unable to Vaccinate" form given to student/school.

SECOND DOSE

VACCINE ☐ IIV4 ☐ LAIV	**ELIGIBILITY** ☐ VFC MEDICAID ☐ VFC AMERICAN INDIAN/ALASKA NATIVE ☐ VFC UNINSURED (NO INSURANCE) ☐ STATE UNDERINSURED ☐ STATE INSURED		
VIS DATE 08/06/2021	**MANUFACTURER**: ☐ GLAXOSMITHKLINE ☐ ASTRA ZENECA ☐ SANOFI PASTEUR **LOT NUMBER**	**SITE OF ADMINISTRATION** ☐ LD ☐ RD ☐ Nasal ☐ Other_____	
NURSE SIGNATURE	Nurse: I hereby attest by signature below that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consent for vaccination.	**DATE** / /	
		ECODE	**COUNTY CODE**
PATIENT'S/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE	Teacher: I hereby attest by signature below that the identity of the patient in question has been verified.	**DATE** / /	

☐ "What to Know After…" given to student ☐ Unable to vaccinate due to _____ "Unable to Vaccinate" form given to student/school.

Notes:

PRE-CLINIC SCREENING- FOR CLINIC USE ONLY

FIRST DOSE ELIGIBILITY: ☐ VFC MEDICAID ☐ VFC AMERICAN INDIAN/ALASKA NATIVE ☐ VFC UNINSURED (NO INSURANCE) ☐ STATE UNDERINSURED ☐ STATE INSURED

SECOND DOSE NEEDED? ☐ NO ☐ YES

SECOND DOSE ELIGIBILITY: ☐ VFC – MEDICAID ☐ VFC AMERICAN INDIAN/ALASKA NATIVE ☐ VFC UNINSURED (NO INSURANCE) ☐ STATE UNDERINSURED ☐ STATE INSURED

STUDENT NAME

MCI Number

Date of Birth / /