El Dorado Public Schools

EL DORADO HIGH SCHOOL
Ph (870)-864-5100
Fax (870)-863-3309

School Immunization Clinic

In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99)

I, ___________________________________, give permission for my child,  
   Parent/Guardian Name

_________________________________________, to participate in the 
   First and Last Name

School Immunization Clinic. I understand that the appropriate Arkansas Department of Health consent 

forms will be provided for my consideration prior to the clinic.

Parent/Guardian Signature ___________________________ Date Signed ______________

School Campus:  El Dorado High School

Grade: _______  Homeroom Teacher: _______________

September 17, 2019
ARKANSAS DEPARTMENT OF HEALTH
INFLUENZA SEASON -- IMMUNIZATION CONSENT FORM

For ADH use only  ADH Clinic Code: School LEA #: Date Of Service: 
School Name: School Grade: 

Person Receiving Vaccine:

(Legal) First Name: MI: Last Name: 
Date of Birth: 

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

*If YES and further guidance is needed, notify the Regional CDNS | YES NO

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a fever today? (If you have a fever on the day of the clinic it may prevent you from receiving the influenza vaccine.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had a serious reaction to a previous dose of flu vaccine, such as difficulty breathing, swelling of eyes or lips, wheezing, or immediate nausea or vomiting? Do you have a severe allergy to any foods or medications? (i.e., gelatin, gentamicin or neomycin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are you younger than 2 years? Yes No |
Are you older than 49 years? Yes No |
Are you pregnant? |

Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? For a child 2 through 4 years: Have you been told by a health care provider that your child had wheezing or asthma in the past 12 months?

Are you on long-term aspirin or aspirin-containing therapy? Do you take aspirin every day? Have you received influenza antiviral medications within the last 48 hours? (Tamiflu, Relenza, Rapivab, Xofluza)

Have you received any of these vaccines in the last 28 days?
Measles, mumps, rubella (MMR) Yes No |
Varicella (chickenpox) Yes No |
Intranasal influenza vaccine (Flu Mist) Yes No |

Do you have a severely weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer, rheumatoid arthritis, Crohn's disease, psoriasis, or radiation treatments)?

Do you have close contact with a person who needs care in a protected hospital environment (for example, someone who has recently had a bone marrow transplant)?

For parents NOT attending flu clinic with their child:
If you answered No to all of the above questions, your child may receive either the flu shot (injectable) or flu mist (nasal spray). Please mark your preference of vaccine type below. **If your preferred vaccine type is not available or marked, the nurse will give what is available unless you indicate otherwise.**

<table>
<thead>
<tr>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu Shot</td>
</tr>
<tr>
<td>Flu Mist</td>
</tr>
<tr>
<td>No Preference</td>
</tr>
<tr>
<td>Do not give if my preference is not available</td>
</tr>
</tbody>
</table>

Child's Homeroom Teacher: (For school clinic use)

- NOTE: Children aged 6 months through 8 years may require a second dose. Contact your health care provider or your ADH Local Health Unit in four weeks for more information.

2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Arkansas Department of Health’s Privacy Notice is on the website www.healthy.arkansas.gov, posted and available at the clinic site, or accompanies this form. Then sign in the box at right.

Please sign here

Signature of Patient/Parent/Guardian: date
RELEASE AND ASSIGNMENT:
- I have read or had explained to me the Vaccine Information Statements for the Inactivated Influenza Vaccine and the Live Attenuated Intranasal Vaccine (Flu Mist) and understand the risks and benefits. To read the Vaccine Information Statement (VIS) for each vaccine visit the website to view current VIS: https://www.cdc.gov/vaccines/hcp/vis-current-vis.html
- I give consent to the State/Local Health Department and its staff for the individual named below to be vaccinated with the flu vaccine.
- I hereby acknowledge that I have reviewed a copy of the Arkansas Department of Health’s Privacy Notice.
- I understand that information about this flu vaccination will be included in the Arkansas Department of Health’s Immunization Registry.

To My Insurance Carrier(s):
- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to the Arkansas Department of Health.
- I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.
- I agree that the photocopy of this form may be used instead of the original.

3. PATIENT INFORMATION:

(Legal) First Name: ___________________________ MI: _______ Last Name: ___________________________

Date of Birth: _______ / _______ / _______ Gender: ☐ Male ☐ Female Phone #: _______________________

Street Address: _______________________________ P.O. Box __________ Apt. No. __________

City: ___________________________ State: ___________ Zip Code: ___________ ___________

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African-American ☐ American Indian/Alaska Native
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other

4. INSURANCE STATUS (Check appropriate box):

Patient’s Relationship to Insurance Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

☐ Medicaid/ARKids Number: ___________________________

☐ Medicare Number: ___________________________

☐ Insurance Company Name: ___________________________

Member ID/Policy #: ___________________________

REQUIRED POLICY HOLDER Information:

(Legal) First Name: ___________________________ MI: _______ Last Name: ___________________________

Policy Holder Date of Birth: _______ / _______ / _______ Email Address: ___________________________

Policy Holder’s Employer Name: ___________________________

Flu Vaccine Administration (Completed by ADH staff only)

SHOT CODE:

☐ 70: Quadivalent (P-F) ≥ 6 months ☐ 39: Quadivalent Intranasal vaccine (P-F) 2 - 49 years

<table>
<thead>
<tr>
<th>Flu Vaccine</th>
<th>Route</th>
<th>Site Code</th>
<th>Dosage mL.</th>
<th>MFG Code</th>
<th>Lot Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intranasal</td>
<td></td>
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</tbody>
</table>

Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

MFG Codes: SK3 = GlaxoSmithKline, PMC = Sanofi, MED = MedImmune, SEQ = Seqirus

Signature and Title of Vaccine Administrator: ___________________________

Date Vaccine Administered: _______ / _______ / _______