MYRTUE Medical Center

Public Health Dept.
(712)755-4422

FLU VACCINE SHOT
2020-2021 SCREENING & CONSENT FOR SCHOOLS

rev 8/8/2020

Student's last name _____ First name _____ Middle name_____

Date of Birth: _____ Age:_____ Circle → Male or Female School/Building_____ Grade/Room _____

Address: _____ City:_____,IA Zip_____

Name of Parent or Guardian_____ Mother's Maiden name_____

Daytime phone: _____

Circle one choice below that pertains to this child:

- Is enrolled in Medicaid MCO and eligible this month? If Yes (no charge) → Must **attach a copy of your Medicaid card.**
- Does not have any health insurance (no charge)
- Has health insurance that DOES NOT pay for flu vaccines (no charge). **Must attach a copy of your insurance card.**
- Is American Indian or Alaskan Native or (no charge)
- OR:
- My child has insurance that pays for vaccine. If the insurance is Wellmark/Blue Cross-Blue Shield fill in:

Blue Cross ID # _____ Group # _____ Blue Cross Policy holder _____

Policy holder's date of birth_____ **Staple a copy of your Blue Cross card to this consent form.**

If you have another kind of insurance that pays for vaccines please staple payment to the consent and ask for a receipt to submit to your insurance company. **Shot $50 FluMist $ 69 Cash or Check #_____** ***Receipt given by*** _____ *(initials)*

I agree to the following:

1. I have seen or been offered a copy of the Vaccine Information Sheet for Influenza dated 8/15/19.
2. To have the child's health insurance billed. If insurance doesn't pay for the whole amount, I agree to pay the difference later.
3. I accept responsibility for seeking medical attention for any problems with this vaccine.
4. The child getting the vaccine does not have a severe allergy to eggs and has never had a severe reaction to a previous flu vaccine.
5. The child getting the vaccine is not moderately to severely ill and does not have COVID symptoms.
6. The child does not have a fever.
7. The child has never had Guillain-Barre Syndrome.
8. If receiving Flu Mist: My child has not had a vaccine in the past 4 weeks. My child has not taken an antiviral vaccine in the previous 48 hours. My child is not on long-term aspirin therapy. My child does not have asthma. My child does not have a weakened immune system nor is in contact with someone with a weakened immune system. My child is not pregnant or possibly pregnant.

I give permission for my child to receive a flu shot at school.

Signature of parent/guardian:_____ Date_____

Date	Circle Source	Injection brand/type or sticker	Dose & Site IM	Signature
	VFC or **Private**		0.5 ml Left Deltoid Right Deltoid	

ENTERED INTO IRIS DATE:_____ INITIALS_____