Georgia Department of Public Health

School Based Influenza Vaccine Consent Form
_____County Health Department

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

STUDENT'S NAME (Last)	(First)	(M.I.)	SCHOOL NAME:	Student ID/Lunch No.:

STUDENT'S DATE OF BIRTH (mm/dd/yyyy)	STUDENT'S AGE	GENDER: M / F	TEACHER	GRADE

ETHNICITY *(Please Circle)* Not Hispanic/Latino Hispanic Latino	RACE *(Please Circle)* African American, White, Hispanic or Latino, American Indian, Asian, Alaska Native, Native Hawaiian, Other Pacific	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

Please check health insurance provider below:

☐Medicaid (Amerigroup, Wellcare, Peach State, Caresource)
☐ Peachcare(Amerigroup, Wellcare, Peach State)
☐ Blue Cross Blue Shield
☐ Aetna
☐ other _____
☐ Cigna
☐ United Healthcare
☐ Coventry
☐ Secure Health
☐ No Insurance

Provide the insurance information for the provider selected & *attach a copy of the insurance card to this form*

Policy Holder Name_____

Policy Holder Date of Birth_____

Group#_____

Member ID #_____

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 each 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:**	
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.	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 conditions, lung conditions, seizure disorders, cerebral palsy, muscle or nerve disorders)	Yes	No
8.	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
9.	Is the student or could the student be pregnant?	Yes	No
10.	Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No
Comments:			

Section 3: Consent: *If this consent form is not filled in completely, signed, dated, and returned, the student will not be vaccinated at school.*

I GIVE CONSENT to the **North Central Health District (NCHD)** ***for the student named above to receive the influenza vaccine.*** I acknowledge that the student and medical information provided above is correct. I have been given a copy of the Vaccine Information Statements for the influenza vaccines. I have had a chance to ask questions which were answered to my satisfaction. I acknowledge that I have reviewed and understand the Notice of Privacy Practices for NCHD which is available at northcentratlhealthdistrict.org or at my local health department. 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 influenza vaccine.

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

FOR CLINIC USE ONLY

Influenza Vaccines		**Date Dose Administered:**	**Mfg:**	**Lot #**	**Exp Date:**	**VIS Date:**	**Signature of Nurse:** _____ **Date:** _____
☐ Quadrivalent (IIV_4)	IM LA / RA					08/15/19	**Entry Clerk Initial:** _____
☐ FluMist	intranasal					08/15/19	**Date:** _____