FORMULARIO DE CONSENTIMIENTO DE LA VACUNA CONTRA LA GRIPE

HEALTH HERO — You Keep Them Smart We Keep Them Healthy

Nombre de la escuela: **Fecha de la clínica:**

POR FAVOR COMPLETE TODA LA INFORMACION A CONTINUACION – **IMPRIMA CON TINTA** (NO SE ACEPTARAN FORMULARIOS INCOMPLETOS)

NOMBRE de Estudiante:	**INICIAL MEDIO**	**APELLIDO de Estudiante:**	
Género: ☐ Hombre ☐ Mujer	**Nacimiento: (mes,dia,ano)** M M D D Y Y Y Y	**Edad** / **Grado**	**Profesor(a) de aula**
Dirección		**Teléfono** — —	**Apellido de soltera de la madre:**
Ciudad	**Código postal**	**Estado**	**Carrera Estudiantil** ☐ Afro Americano/Negro ☐ Blanco ☐ Asiático ☐ Hawaiano/Isleño del Pacífico ☐ Alaskan/ Nativo-Americano ☐ Otro **Etnicidad** ☐ Hispana ☐ No-Hispana
Dirección de correo electrónico:			

Las leyes vigentes en materia de atención médica nos obligan a facturar la vacuna a su compañía de seguros. El servicio se ofrece sin costo para usted. Las respuestas son siempre confidenciales.

☐ **Mi hijo(a) NO tiene seguro** ☐ **Mi hijo(a) tiene Medicaid** VFC eligible	☐ **Mi hijo(a) tiene Seguro Comercial: Proporcione el nombre de la compañía de seguros** Not VFC Eligible
Nombre del Titular de la póliza	**Apellido del Titular de la póliza**
ID de miembro:	**Fecha de nacimiento del titular de la póliza: (mes,dia,ano)** M M D D Y Y Y Y

MARQUE SI O NO PARA **CADA** PREGUNTA

SI	NO	
☐	☐	1. ¿Ha tenido su hijo(a) alguna vez una reacción potencialmente mortal a la vacuna contra la gripe en el pasado?
☐	☐	2. ¿Su hijo(a) ha tenido algunza vez el síndrome de Guillain-Barre?
☐	☐	3. ¿Su hijo(a) tiene alergia a los huevos?
☐	☐	4. ¿Su hijo(a) tiene un trastorno de la sangre como hemofilia?
☐	☐	5. ¿Será la primera vez que su hijo(a) reciba una vacuna contra la gripe?

SI TIENE ALGUNA PREGUNTA DE SALUD, POR FAVOR CONTACTE CON EL PEDIATRA DE SU HIJO(A) O LLAMENOS AT 205-609-0268 PARA HABLAR A CON UN REPRESENTANTE.

He leído la información sobre la vacuna y las precauciones especiales en la Hoja de Información de Vacunas. Soy consciente de que puedo localizar la Declaración de Información sobre Vacunas más reciente y otra información en www.immunize.org o www.cdc.gov. He tenido la oportunidad de hacer preguntas sobre la vacuna y entender los riesgos y beneficios. Solicito y consiento voluntariamente que la vacuna se dé a la persona mencionada anteriormente de quien soy el padre o tutor legal y que tenga autoridad legal para tomar decisiones médicas en su nombre. Reconozco que no se han hecho garantías sobre el éxito de la vacuna. Por la presente libero el sistema escolar, HNH Immunizations, Inc, MaxVax LLC., y subsidiarias, escuelas afiliadas de enfermería, sus directores y empleados de cualquier y toda responsabilidad que surja de cualquier accidente o acto de omisión que surja durante la vacunación. Entiendo que este consentimiento es válido por 6 meses y que voy a hacer que la escuela sea consciente de cualquier cambio de salud antes de la fecha de la clínica de vacunación. Reconozco que estoy dando permiso a HNH Immunizations para resolver y apelar con mis proveedores de seguros en mi nombre. Las fechas de la clínica se pueden obtener de la escuela. Entiendo que la información relacionada con la salud en este formulario se utilizará para fines de facturación de seguros y su privacidad estará protegida. Solicito y consiento voluntariamente que se le dé la vacuna y se registre en Immprint para la persona mencionada anteriormente. Soy el padre o tutor legal y tengo autoridad legal para tomar decisiones médicas en su nombre..

Nombre impreso del padre/tutor legal con Autoridad para Autorizar vacunas	Firma del Padre/Tutor legal con Autoridad para Autorizar vacunas	Relación con el/la niño(a)	Fecha

VIS CDC IIV 08/06/2021 INFLUENZA
LOT Number: **EXP Date:**
RN #_____ Date:_____
AREA FOR OFFICIAL ADMINSTRATION USE ONLY

HNH Immunizations Inc.
326 Prairie Street North
Union Springs, AL 36089
AL@healthherousa.com
205-609-0268

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season.

Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at www.fda.gov/vaccines-blood-biologics/vaccines.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at www.cdc.gov/flu.