

2021-2022 School Based Influenza Vaccine Consent Form

Carroll County Health Department

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

	T					
STUDENT'S NAME (Last)	(First) (M.I.)			SCHOOL NAME:	NAME:	
STUDENT'S DATE OF BIRTH	STUDENT'S AGE GENDER		M / F	TEACHER	GRADE	
(mm/dd/yyyy)						
(,, , , , , , , , , , , , , , ,						
ETHNICITY (Please Circle)	RACE (Please Circle) African American, White,			PARENT/ LEGAL GUARDIAN'S NAME		
Not Hispanic/Latino Hispanic Latino	Hispanic or Latino, American Indian, Asian,					
	Alaska Native, Native Hawaiian, Other Pacific					
HOME ADDRESS	PARENTAL/ GUARDIAN PHONE NUMBER(S)					
CITY STATE			ZIP CODE	PARENTAL/ GUARDIAN E-MAIL		
INSURANCE INFORMATION: Do you have Ins	Provide the insurance information for the provider selected					
Please check health insurance provider belo	& attach a copy of the insurance card to this form					
Aetna .	Medicaid No Insurance			Policy Holder Name		
	PeachCare Dther			Group#		
Cigna	United Healthcare					
				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.	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)		No	
8.	Is the person to be vaccinated receiving influenza antiviral medications?		No	
9.	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	
10.	Is the student or could the student be pregnant?	Yes	No	
11.	1. Has the student ever had Guillain-Barre Syndrome (GBS)?			

Section 3: Consent: The vaccine consent form includes options allowing you to either accept or refuse the vaccination for your child. If you refuse, the vaccination will not be given to your child. 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 [NAME OF ORGANIZATION CONDUCTING CLINIC] for the student named above to receive the influenza vaccine. Lacknowledge 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 and the NOTICE of PRIVACY POLICY FORM. I have had a chance to ask questions which were answered to my satisfaction. 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 intranasal or injectable influenza vaccine.

Signature of Parent/Legal Guardian:

I DO NOT GIVE CONSENT to the [NAME OF ORGANIZATION CONDUCTING CLINIC] and its staff for the student named above of this form to be vaccinated with this vaccine.

Sianature of Parent/Leaal Guardian:

Signature of Parent											
FOR CLINIC USE ONLY											
Influenza Vaccine:	Adm Route:	Date Dose Administered:	Mfg:	Lot #	Exp Date:	VIS Date:	Signature of Nurse: Date:				
Inactivated Influenza Vaccine - Quadrivalent (IIV ₄)	IM: LA / RA	/ /			/ /	/ /	Entry Clerk Initial:				
☐ Live Attenuated Influenza Vaccine – Quadrivalent (LAIV₄)	Intranasal	/ /			/ /	/	Date:				

Date: