Flu Vaccine Consent Form



School Name:

Clinic Date:

| | | PLEA: | SE CON | APLE | TE A | \LL | OF T | HE IN | VFC | RM. | ATIC | ON B | ELO | <i>N</i> - F | Pleas | e pri | nt us | ing | ink | (Inc | ompl | ete fo | rms | will r | not be | acc | epted |) | | | |
|---|--|---|---|--|--|--|--|--|--|---|---|---|---|---|---|--|---|---|--|--|---|--|--|--|--|--|--------------------------------------|--|-------------------|--|--|
| FIRST NAW of Student: | | | | | | | | | | MIDI | | | | ST N Stude | | | | | | | | | | | | | | | | | |
| Gender: Male Female Birthdate: (mo,day,yr) | | | | | | | | | | | | Ag | ie | | | Но | mei | ооп | Tea | cher | / Gra | de | | | | | | | | | |
| Address | | | | | | | | | · ' | Phone # () - Mother's Maiden Name: (For registry) | | | | | | | | | | | | _ | | | | | | | | | |
| City Zip Code | | | | | | | | State | | | | | | Student Race: (Circle one) African American Asian Hawaiian / Pacific Islander Other Ethnic | | | | | | | | | | | | | | | | | |
| Email address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential. Please fill out the following questions pertaining to your child's health insurance: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medicaid My child does NOT have health insurance | | | | | | | | | | | 1 | Insurance Company: | | | | | | | | | | | | | | | | | | | |
| Policy Hol | | ; | | | | | . 1 | | | | | | | | lder's | | | | T | | | | | | | | | | = | | |
| Member ID: | | | | | | | | | | | | | Polic | | lder's | Date | of Bir | th: | <u> </u> | | - | | | | | | | | - | | |
| | ID: (mo,day,yr) CHECK YES OR NO FOR <u>EACH</u> QUESTION | | | | | | | | | | | | | | _ | | | | | | | | | | | | | | | | |
| YES N | 10 | 1 Has | vour | hild a | vor h | ad a | | | | | | | | | | | | | aet' | | | j | . Commission of the Commission | | Ħ | | | | | | |
| | _ _ | 1. Has your child ever had a life-threatening reaction(s) to the flu vaccine in the past? 2. Has your child ever had Guillain-Barre' syndrome? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | _ | | | | | | | | | - | aror | ne? | | | | | | | | | | _ | | | | - | | - | 1000000 | | |
| | | | s your | | | | | | | | | | | | | | | | | | | | ret | urn | do <u>l</u> this | foru | n | | and have grant be | | |
| | | 4. Doe | s your | child | have | e a b | lood | disor | der | such | n as | hemo | phili | ia? | | | | | | 1 | | | you | ır el | you hild | to b | | | · Physician | | |
| |] | 5. Will | this be | the f | irst ti | ime | your | child I | has | eve | r red | ceive | d a fl | u va | ccina | ation' | ? | | | | 1 | | , | /acc | inate | ed. | | | | | |
| | | IF YOU H | AVE ANY | HEALT | 'H QUE | ESTIO | NS, PLE | EASE C | ONT | ACT Y | OUR (| CHILD' | S PEDI | ATRIC | CIAN C | R CAL | LUS | AT 20 |)5-60 | 9-026 | 8 TO | SPEA | KTO |) A R | EPRE | SEN | TATIV | E. | | | |
| I have read information vaccine to b made conce any and all changes pri dates can b voluntarily control of the | at www. eming liabilition to liabilition to liabilitii to liabiliti | w.immunize on to the pe the vaccine y arising fro the vaccinal sined from t | e org or ww rson listed e's success m any acc tion clinic d he school. | w.cdc.e above of a l here ident or late. I ad I under | gov. I hof whom by rele act of eknowlestand t | nave ham I am ase th omiss edge t hat the | ad an op the par e school ion which hat I am e health | oportunil rent or le ol system th arises giving prelated | ly to a egal g n, HN s duric permi infort | ask que juardia IH Imm ng vaco ission f mation | estions on and ounization cination for HN on this | s regard having tions, In on. I und IH Immu s form t | ling the legal a c., Max lerstand inization | e vacci authoria «Vax L d this a ans, In | ne and by to m LC., & conser c. to ac | l under: ake me subsid it is vali ljudicat | stand t dical d iaries, d for 6 e and : | he ris ecisi affilia mon appe | sks ar ons o ated s ths ar al clai | nd ber n thei chool nd tha ims w | nefits. r beha s of n it I wil ith my | I requalf. I ac ursing I make insur | est a cknow , thei e the ance | nd vo wledg r dire school prov | oluntar pe no g ctors a ol awa iders d | rily co guara and e are of on my | ntees i mploye any he behal | for the nave been eas from ealth f. Clinic | 1 | | |
| Printed N | Name | e of Parer | t/Guardi | an | | _ | TH . | Sign | atur | e of P | aren | t/Gua | dian | | | Relati | onshi | p to | Chil | d | | | | | Date | ; | | | | | |
| VIS CDC I LOT Num RN#_ AREA | ber: | | CIAL | Date: | Date | 1 | ATIO | ON U | - JSE | ON | ΙLΥ | | | 326 F Unior <u>AL@</u> | rairie Sprir health | muni St. No Igs, Al Inherol 9-02 | rth . 3608 .sa.co | 19_ | i Inc | С. | | V. | H | N | H | V | | | | | |

VACCINE INFORMATION STATEMENT

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

Many veccine information statements are mediate in Specials and other barginger.

Regios de información tedere recentes están dispunibles est especial y est mechan estra idioanas. Visits waves inameniza orgánia

1. Why get vaccinated?

influenza vaccine can prevent influenza (flu).

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

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

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

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

2. Influenza vaccines

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

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

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

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

Influenza vaccine does not cause flu

influenza vaccine may be given at the same time as

Talk with your health care provider

Tell your vaccination provider if the person getting

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

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

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

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

Intermation. Your health care provider can give you more

4. Risks of a vaccine reaction

6. The National Vaccine Injury

Compensation Program

- 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).

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

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

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

5. What if there is a serious problem?

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

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

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

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

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 www.fda.gov/vaccines-blood-biologics/vaccines. inserts and additional information at Administration (FDA) for vaccine package
- Prevention (CDC): Contact the Centers for Disease Control and
- Visit CDC's website at www.cdc.gov/flu Call 1-800-232-4636 (1-800-CDC-INFO) or

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

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

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Clinic Date:

| | PLEASI | E COMP | LETE | ALL (| OF TH | E IN | FORM | IATI(| ON B | ELO | <i>N</i> - Pl€ | ease | e prii | it usi | ng ir | 1 k (Ir | ncompl | ete for | ms wi | ll not l | oe acc | epted) | |
|--|--|------------------------------|-----------------------------|------------------------|---------------------------------------|----------------------|-----------------------|----------------------|--------------------|--|--|---------|---------|----------|----------|----------------|------------|-----------|---------------|---------------|-------------|----------|---------|
| FIRST NAME of Student: | | | | | | | | IDDLE ITIAL | | | ST NAM Studen | | | | | | | | | | | | |
| Gender: Male Female Birthdate: (mo,day,yr) | | | | | | | | | | Ag | е | | | Hoi | neroo | m Te | acher | / Grad | le | | | | |
| Address | | | | | | | | | | Phone # () - Mother's Maiden Name: (For registry) | | | | | | | | | | | | | |
| City Zip Code State | | | | | | | | | | | Student Race: (Circle one) African American / Black White Alaskan/ Native-American Asian Hawaiian / Pacific Islander Other Ethnicity: (circle one) Hispanic Non-Hispanic | | | | | | | | | | | | |
| Email addres | is: | | | | | | | | | 1.2 | | | | | | | | | | | | | |
| The current health care laws require us to bill your insurance company for the | | | | | | | | | | cine. | The se | rvice | is of | ered a | t no | cost | o you. | Ansv | vers a | re alv | lays (| onfide | ential. |
| | Please fill out the following questions pertaining to your child's health insurance: | | | | | | | | | | | | | | | | | | | | | | |
| Medicaid My child does NOT have health insurance | | | | | | | | | | Insurance Company: | | | | | | | | | | | | | |
| Policy Holder | 's | | | | | | | T | | Polic | y Holde | er's | Т | | | | | 1 | Ī | Ī | | | |
| First Name: | <u> </u> | | | | | | | | | Last | Name: | | Ш, | | | | | | <u> </u> | | | | |
| Member ID: | | | | | | | | | | | Policy Holder's Date of Birth: (mo,day,yr) | | | | | | | | | | | | |
| | CHECK YES OR NO FOR <u>EACH</u> QUESTION | | | | | | | | | | | | | | | | | | | | | | |
| YES NO | | | | | | | | | | | | | | | | | | 1 | | • | | 1 | |
| | 1. Has your child ever had a life-threatening reaction(s) to the flu vaccine in the past? | | | | | | | | | | | | | | | | | | | | | | |
| | 2. Has your child ever had Guillain-Barre' syndrome? STOP The syour child ever had Guillain-Barre' syndrome? | | | | | | | | | | | | | | | | | | | | | | |
| | 3. Does | your ch | ild have | an a | allergy | to e | ggs? | | | | | | | | | | | | | | NOT | | |
| | 4. Does | your ch | ild have | a ble | ood di | isord | er suc | h as | hemo | phili | a? | | | | | | | ì | ınles | s you | wan | t, | J |
| | 5. Will th | is be th | e first ti | me y | our ch | nild h | as eve | er rec | eived | l a flu | ı vacc | inat | ion? | | | | 1 | 1 | vac | cina(| ted. | 1 | |
| | IF YOU HAV | E ANY HE | ALTH QUE | STION | S, PLEA | SE CO | NTACT | YOUR C | CHILD'S | PEDIA | TRICIA | N OR | CALL | US AT | 205-6 | 09-02 | 68 TO : | SPEAK | TOA | REPR | ESEN | TATIVE | |
| | | | | | | | | | · · · · · · · · | | | M4 6 | | | | | -11/ | to a dode | | - 01-1 | | | |
| I have read the information at www. vaccine to be give | w.immunize.or | g or www.o | dc.gov. I h | ave had | an oppo | ortunity | to ask qu | uestions | regard | ing the | vaccine a | and u | nderst | and the | risks a | and be | enefits. I | reque | st and | volunta | arily co | nsent fo | r the |
| made concerning any and all liabilit | the vaccine's | success. I f | nereby rele | ase the | school s | ystem, | HNH Imr | munizat | ions, Ind | ., Max | Vax LLC. | ., & ડા | ubsidia | ries, af | filiated | schoo | ls of nu | rsing, t | heir diı | ectors | and e | mployee | s from |
| changes prior to to dates can be obta voluntarily conse | the vaccination ained from the | clinic date. school. I ur | . I acknowk iderstand ti | edge that nat the f | at I am gi health-re | iving pe lated in | rmission formation | for HNI n on this | H Immu s form w | nizatior | s, Inc. to | adju | dicate | and ap | peal cla | aims v | vith my | insuran | ice pro | viders | on my | behalf. | Clinic |
| Touristiny contact | nt for the vacou | no to bo giv | 011 011 010 | 0,000 1 | · · · · · · · · · · · · · · · · · · · | | o porou. | 110100 | | | | | | | | | | | | | | | |
| Printed Name | e of Parent/0 | Guardian | | | (| Signat | ure of f | Parent | /Guar | dian | | Re | elatio | nship | to Ch | ild | - | | | Date | | | |
| 140.000.000 | No reas | 49.5 | F1 1 1 F 2 1 - 1 | | | | | | | L | INH Ir | 77.00 | unis | atio | ne In | | | - 46 | er git | Mr. 194 . | | | |
| VIS CDC IIV 08/06/2021 INFLUENZA LOT Number: EXP Date: | | | | | | | | | 3 | 26 Prair | rie St | . Nort | h | | ю. | | بو | UNIZ | TANGE . | V | | | |
| RN#Date:AREA FOR OFFICIAL ADMINSTRATION USE ONLY | | | | | | | | | | Union Springs, AL 36089 AL@healthherousa.com | | | | | | | | | | | | | |
| AREA FOR OFFICIAL ADMINISTRATION USE ONLY | | | | | | | | | | | 205-6 | 09. | -026 | 8 | | | | V/8063 | man and | With a series | | | |