2026-27 School Based Influenza Vaccine Consent Form

VHN Number:

School Name _____

If you do NOT want your child to receive flu vaccine, do NOT fill out or return form.

Section 1: Information About the Student Who Will Receive Influenza Vaccine (please print)

STUDENT'S FIRST NAME	MIDDLE INITIAL	(LAST NAME)	NICKNAME (Name student goes by at school)	
DATE OF BIRTH (mm/dd/yyyy)	AGE	GENDER (*Please check*) ☐ Male ☐ Female	HOMEROOM TEACHER	GRADE

ETHNICITY *(Please Check)*
Hispanic/Latino ☐ Yes ☐ No

RACE *(Please Check)*:
☐ African American/Black ☐ White ☐ Hispanic or Latino
☐ American Indian ☐ Asian ☐ Alaska Native
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other

PARENT/ LEGAL GUARDIAN'S NAME

HOME ADDRESS

PARENT/ GUARDIAN PHONE NUMBER(S)

CITY STATE ZIP CODE

**Provide insurance plan information below.*

INSURANCE INFORMATION: Does your child have Insurance that covers vaccines? ☐ Yes ☐ No

If "Yes," please check health insurance provider below & complete the information to the right*:

☐ Aetna
☐ Ambetter
☐ Anthem BCBS
☐ Cigna
☐ Medicaid/PeachCare/Amerigroup/Peachstate/CareSource
☐ United Healthcare
☐ UMR
☐ TRICARE Standard ONLY
☐ CareSource Marketplace
☐ No Insurance
Other

Name of Policy Holder/Name on ID Card: _____

Member ID#:

Group#/Policy Type (HMO, PPO, CMO): _____

Please attach a copy of the insurance card to this form.

Section 2: Medical Information: The following questions will help us to determine if this student can receive the influenza vaccine.

**Please check Yes or No for every 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 or Year		
3.	Has the student ever had a serious allergic reaction to eggs?	Yes	No
4.	Has the student ever had a serious reaction to any influenza (flu) 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 every day)	Yes	No
7.	Does the student have any significant or chronic (long term) health conditions? (For example: diabetes, sickle cell disease, heart condition, lung condition, seizure disorder, cerebral palsy, muscle or nerve disorder, juvenile arthritis)	Yes	No
8.	Does the student have a weak immune system? (For example, from HIV, cancer, or from taking medications such as steroids or those used to treat cancer?)	Yes	No
9.	Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No
10.	Adolescent females only: Is the student pregnant?	Yes	No
11.	Is the person to be vaccinated receiving influenza antiviral medications?	Yes	No

Section 3: Consent to vaccinate

If this consent form is not filled out completely, signed, dated, and returned, the student will not be vaccinated at school.

CONSENT FOR STUDENT TO RECEIVE INFLUENZA VACCINE

By signing below, I acknowledge that the student and medical information provided above is correct. I have been given a copy of the VACCINE INFORMATION STATEMENT (VIS) for INFLUENZA VACCINE or a QR code to view the VIS for INFLUENZA VACCINE. 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. I understand that it is my responsibility to notify the school and the participating health department at least three business days prior to the school-based flu vaccination clinic event if my child has already received a flu vaccine by another provider this year.

By signing below, I give permission for the student listed above to receive flu vaccine.

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

FOR CLINIC USE ONLY

Inactivated Influenza Vaccine 2026-27
Administration Route: ☐ IM / LEFT Deltoid ☐ IM / RIGHT Deltoid

Vaccine Code: _____
Lot # _____
Exp Date: _____
Vaccine Administration Date _____

English
Influenza (Flu) Vaccine
Vaccine Information Statement

Nurse Signature: _____ **Date:** _____ **Entry Clerk Initial:** _____ **Date:** _____

PUBLIC **$PRIVATE$**