Georgia Department of Public Health
Southeast Health District

# 2022-23 SCHOOL BASED INFLUENZA VACCINE CONSENT FORM

**SCHOOL NAME** _____

**If you do NOT want your child to receive flu vaccine at school, please do NOT fill out or return this 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): | |
|---|---|---|---|---|
| | | | | |
| **DATE OF BIRTH (mm/dd/yyyy)** | **AGE** | **GENDER (*Please circle*)** Male Female | **HOMEROOM TEACHER** | **GRADE** |
| | | | | |
| **ETHNICITY *(Please Check)*** Hispanic/Latino ☐ Yes / ☐ No | **RACE *(Please Circle)***: African American/Black, White, 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** *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* | |
| **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 ☐ Blue Cross/Blue Shield ☐ Cigna ☐ Coventry ☐ Medicaid/Amerigroup/Peachstate/Wellcare/CareSource ☐ Peachcare for Kids ☐ United Healthcare ☐ Other_____ ☐ No Insurance | | | | |

**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 every question.***

| | | | |
|---|---|---|---|
| **1.** | When was the student last vaccinated for flu (if known)? | **DATE:** | |
| **2.** | Has the student ever had a serious allergic reaction to eggs? | **YES** | **NO** |
| **3.** | Has the student ever had a serious reaction to any influenza (flu) vaccine? | **YES** | **NO** |
| **4.** | Has the student ever had Guillain-Barré Syndrome (GBS)? | **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 received a copy of the VACCINE INFORMATION STATEMENT for INFLUENZA VACCINE and the NOTICE of PRIVACY POLICY FORM. I was given the opportunity 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 above. I understand that participation and receipt of the influenza vaccine through this program is completely voluntary.***

**By signing below, I give consent for the student listed above to receive flu vaccine at school.**

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

**FOR CLINIC USE ONLY**

VIS: Inactivated Influenza Vaccine 8/06/2021

**Administration Route**: ☐ **IM / LEFT Deltoid** ☐ **IM / RIGHT Deltoid**

Mfg: _____

Lot # _____

Exp Date: _____

_____
**NURSE SIGNATURE**

_____
**DATE**

**Demographic/Insurance information entered/updated by: _____ Date:_____**

| **PUBLIC** | **$PRIVATE$** | **PIN#:** |
|---|---|---|