2017-2018 Seasonal Flu Vaccine Consent Form
THIS FORM MUST BE RETURNED

(incomplete, unreadable, or unsigned forms may not be accepted)

THIS SEASON, CONTROL FLU WILL BE VACCINATING WITH THE FLU SHOT

Full, Legal Name of Student *(First Name Middle Initial. Last Name)* **PLEASE PRINT**		**Name of School**	
Parent/Guardian Name *(First Name Middle Initial. Last Name)*	**Relationship to Student**	**Homeroom Teacher**	**Grade**
Street Address	**Email Address**	**Birth Date (month/date/year)**	**Age Sex**
City:	**Zip Code**	**Home Phone #**	**Cell Phone #**

Demographic Information: (Circle one) White American Indian/Native Alaskan Black Asian Hispanic Other

☐ **INSURANCE** ☐ **MEDICAID (Prestige, UHC Community, StayWell/Wellcare, & Sunshine)** ☐ **MY CHILD DOES NOT HAVE HEALTH INSURANCE**

The current health care laws require us to bill your insurance company for the vaccine. You will not be billed, and there will be no co-pay or deductible due. The service is offered at no cost to you! As always, answers are confidential. Please fill out the following questions regarding your child's health insurance plan:

Insurance Company:	Member ID:
Policy Holder's Name:	Policy Holder's Date of Birth:

HEALTH QUESTION: ***(If you answer YES, your child cannot receive a Flu shot unless approved by your child's health care provider)***

Yes	**No**	**1. Do any of the following apply to your child?**	
☐	☐	• **Severe allergy to chicken eggs or egg products** • **Life threatening reaction(s) to flu vaccine in the past**	• **Has had Guillain-Barre syndrome (very rare)**

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S HEALTH CARE PROVIDER OR CALL THE ALACHUA COUNTY HEALTH DEPARTMENT IMMUNIZATION CLINIC AT 352-334-7950.

If your child has any long-term health problems with weakened immune system, heart disease, lung disease (e.g. cystic fibrosis), liver disease, kidney disease, or metabolic disorders (e.g. diabetes) or blood disorders (e.g. sickle disease or thalassemia), please see your health care provider for a flu vaccine.

I have received, read, and understand the CDC Vaccine Information Statement for the inactivated influenza (shot) vaccine and the Notice of Privacy Practices. I have read these documents and understand the risk and benefits of the Flu vaccine. I give permission to the State of Florida, Department of Health to give my child the first and second dose (if needed) of the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Florida Department of Health policies, to assure optimal healthcare for my child.

☐ **YES, I Want to Protect My Child, Family and Community from Flu by allowing my Child to receive the Flu Shot!**

Please return to the school, FAX to (352) 334-7947, or EMAIL to; SLIV@flhealth.gov

(Please note that e-mailing may not be a secure method of communication)

______________________________ ______________________________ ______________

Printed Name of Parent/Guardian Signature of Parent/Guardian Date

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

1st dose **VIS: 08/07/2015**	1st Vaccine Lot # & Expiration Date Label	**2nd dose** **VIS: 08/07/2015**	2nd Vaccine Lot # & Expiration Date Label
Date Given: _______________		Date Given: _______________	
Signature/Title _______________		Signature/Title _______________	

Notes: