Student Flu Vaccine Consent & Release Form

PLEASE PRINT **COMPLETE FORM FOR EACH CHILD**

STUDENT'S NAME (Last)	(First)	(M.I.)	**STUDENT'S DATE OF BIRTH** / /	
PARENT/GUARDIAN'S NAME (Last)	(First)	(M.I.)	**Circle Gender** M F	**Student's Age**
ADDRESS			**PHONE:** **Daytime:** **Home:** **Cell:**	
CITY and STATE	**ZIP**			
SCHOOL NAME	**SCHOOL TOWN**		**GRADE** (circle one) K 1 2 3 4 5	
HOMEROOM TEACHER'S NAME (Last, First) and **HOMEROOM NUMBER**			**PHYSICIAN'S NAME:**	

This vaccination program is free to all elementary students; however, for program purposes we need the following information.
Please check the section that applies to your child: ( ) Medicaid Enrolled ( ) has no health insurance
( ) American Indian/Alaskan Native ( ) Has health insurance that does NOT pay for influenza vaccines
( ) Has health insurance that DOES pay for influenza vaccines

The following questions will help us to determine if your child can get the influenza vaccine.

Please mark **YES** or **NO** for each question:	**YES**	**NO**
1. Does your child have a serious allergy to eggs?	☐	☐
2. Does your child have any other serious allergies? Please list:	☐	☐
3. Has your child ever had a serious reaction to flu (influenza) vaccine in the past?	☐	☐
4. Has your child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness)?	☐	☐

Consent for Child's Vaccination

I have read the Vaccine Information Statement for the ***Inactivated Influenza Vaccine for the 2018-2019 season*** or have had the information explained to me. I have had a chance to ask questions, which were answered to my satisfaction. I understand and acknowledge the benefits and risks of influenza vaccine and request that the vaccine be given to my child at school. I accept responsibility for seeking medical attention for any problems with this vaccination. I understand that if my child requires two doses of flu vaccine, it is my responsibility to get this second dose for my child. I acknowledge that I have read a Genesis Health System Notice of Privacy Practices. **I give consent for my child, for whom I am authorized to make this request, to Genesis and its' staff for my child to be vaccinated at school.**

Signature of Parent/Guardian ______________________ Date: ____/____/____

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Site	Route	Vaccine Manufacturer	Lot Number	Expiration Date
2018-2019 Inactivated Influenza	/ /	RD LD	IM 0.5 ml			
Name & Title of Vaccine Administrator:						