



2019-2020 Seasonal Flu Vaccine Consent Form

Please Return Form by September 25, 2019

PLEASE COMPLETE THE INFORMATION BELOW (Unreadable and incomplete 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?	
<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Severe allergy to chicken eggs or egg products Life threatening reaction(s) to flu vaccine in the past 	<ul style="list-style-type: none"> 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 Help Protect My Child, Family And Community From Flu By Allowing My Child To Receive the Flu Shot!

NO, I do not want my child to receive the flu shot vaccine at school, because _____
(Optional)

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

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

1st dose VIS: 08/07/2015 Date Given: _____ Signature/Title _____	<div style="border: 1px solid black; padding: 5px; text-align: center;"> 1st Vaccine Lot # & Expiration Date Label </div>	2nd dose VIS: 08/07/2015 Date Given: _____ Signature/Title _____	<div style="border: 1px solid black; padding: 5px; text-align: center;"> 2nd Vaccine Lot # & Expiration Date Label </div>
--	--	--	--

Notes: