Georgia Department of Public Health

# DO NOT COMPLETE IF YOU DO NOT WANT YOUR CHILD VACCINATED

2021-2022 School Based Influenza Vaccine Consent Form

**Thomas County Health Department**

## Section 1: Information about Student to Receive Influenza Vaccine (please print)

| | | | | |
|---|---|---|---|---|
| STUDENT'S NAME (Last) | (First) | (M.I.) | SCHOOL NAME: | |
| STUDENT'S DATE OF BIRTH (mm/dd/yyyy) | STUDENT'S AGE | GENDER: M / F | TEACHER | GRADE |
| ETHNICITY *(Please Circle)*<br>Not Hispanic/Latino Hispanic Latino | RACE *(Please Circle)* African American, White, Hispanic or Latino, American Indian, Asian, Alaska Native, Native Hawaiian, Other Pacific | | PARENT/ LEGAL GUARDIAN'S NAME | |
| HOME ADDRESS | | | PARENTAL/ GUARDIAN PHONE NUMBER(S) | |
| CITY STATE | | ZIP CODE | PARENTAL/ GUARDIAN E-MAIL | |

**INSURANCE INFORMATION: Do you have Insurance that covers vaccines?** ☐Yes / ☐No

**Please check health insurance provider below:**

☐ Aetna/Coventry ☐ Medicaid ☐ No Insurance
☐ Blue Cross Blue Shield ☐ PeachCare ☐ Ambetter, Amerigroup
☐ Cigna ☐ United Healthcare Caresource

**Provide the insurance information for the provider selected & *attach a copy of the insurance card to this form***

Policy Holder Name_____

Group#_____

Member ID #_____

## 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 each 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:** | |
| 3. | Has the student ever had a serious reaction to eggs? | Yes | No |
| 4. | Has the student ever had a serious reaction to any influenza 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 everyday) | Yes | No |
| 7. | Does the student have any significant or chronic (long term) health conditions? (For example: diabetes, sickle cell disease, heart conditions, lung conditions, seizure disorders, cerebral palsy, muscle or nerve disorders) | Yes | No |
| 8. | Is the person to be vaccinated receiving influenza antiviral medications? | Yes | No |
| 9. | Does the student have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)? | Yes | No |
| 10. | Is the student or could the student be pregnant? | Yes | No |
| 11. | Has the student ever had Guillain-Barre Syndrome (GBS)? | Yes | No |

## Section 3: Consent: *The vaccine consent form includes options allowing you to either accept or refuse the vaccination for your child. If you refuse, the vaccination will not be given to your child. If this consent form is not filled in completely, signed, dated, and returned, the student will not be vaccinated at school.*

☐ **I GIVE CONSENT** to the **Thomas County Health Department** ***for the student named above to receive the influenza vaccine.*** I acknowledge that the student and medical information provided above is correct. I have been given a copy of the Vaccine Information Statements **8/6/21 for** the influenza vaccines and the NOTICE of PRIVACY POLICY FORM. 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. By signing below, I give permission for the student listed above to receive the intranasal or injectable influenza vaccine.

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

☐ **I DO NOT GIVE CONSENT** to the **Thomas County Health Department** and its staff for the student named above of this form to be vaccinated with this vaccine.

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

| Type Vaccine | Date Administered | Mfg. /Lot#/Exp. Date | Administration Route | Nurse Signature | |
|---|---|---|---|---|---|
| **1st Inactivated: VFC /CP**<br>**2nd Inactivated: VFC/CP** | **1st** _____<br>**2nd** _____ | **1st** _____<br>**2nd** _____ | **IM / LD/LM RD/RM**<br>**IM / LD/LM RD/RM** | **1st** _____<br>**2nd** _____ | **GRITS Check: Date and Verified By:** _____ |
| **Allergy Status Verified** | **Right Vaccine/No contraindications** | **Right Formulation for Patient's Age** | **Right Patient/Verify @ Minimum Name and DOB** | **Expiration Date Valid** | **Right Dose/Route** |