Thomas County Health Department
2014-2015 Influenza Vaccine Consent Form/School-Based Flu Clinics

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)* Not Hispanic/Latino Hispanic/Latino	RACE *(Please Circle)* African American, White, American Indian, Asian, Alaska Native, Native Hawaiian, Other Pacific Islander, Other		PARENT/ LEGAL GUARDIAN'S NAME	
HOME ADDRESS			PARENTAL/ GUARDIAN PHONE NUMBER(S)	
CITY STATE		ZIP CODE		

INSURANCE INFORMATION: Do you have Insurance that covers vaccines? Yes / No Check health insurance provider below. (You will not be charged for this vaccine.) ☐ BCBS Policy/Group # _____/_____ ☐ AETNA Policy/Group # _____/_____
☐ Medicaid/Wellcare/Peachstate/Amerigrup/Peachcare # _____ ☐No Insurance ☐Other: _____

Section 2: Medical Information. The following questions will help us to know if this student can receive the 2014-2015 Influenza Vaccine.

Please circle Yes or No for each question.

1. Has the student ever had a serious reaction to any influenza vaccine?	Yes	No
2. Has the student child ever had a serious reaction to eggs?	Yes	No
3. Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No
4. a.) Does the student have asthma or a wheezing condition? b.) If YES, does your child use inhalers and/ or breathing treatments?	a. Yes b. Yes	a. No b. No
5. Is the student on long-term aspirin or aspirin-containing therapy (For example: does your child take aspirin everyday)	Yes	No
6. 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, etc.)	Yes	No
7. 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
8. Is the student or could the student be pregnant?	Yes	No
9. Has the student received any vaccines in the last four weeks? If yes, please list: _____	Yes	No
10. Is the student allergic to latex?	Yes	No

Section 3: Consent:

***If you selected YES TO QUESTION 1 - 3 in section 2 your child WILL NOT be able to receive INJECTABLE OR INTRANASAL flu vaccine at school.* Contact your healthcare provider regarding flu vaccine for your child. *If you selected YES to any of QUESTIONS 4-8 in section 2, your child WILL NOT be able to receive the INTRANASAL vaccine and CAN ONLY RECEIVE the INJECTABLE vaccine.**

CONSENT FOR STUDENT TO RECEIVE INFLUENZA VACCINE: ***By signing below, I give permission for the student named above to receive the 2014-2015 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 (VIS) 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 and have received a copy of the VIS for influenza vaccine dated 08/19/2014. 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. **The consent form will provide permission to vaccinate for both doses, if needed. (See VIS) If this consent form is not filled in completely, signed, dated, and returned, the student will not be vaccinated at school.**

Signature of Parent/ Legal Guardian: _____ Date: _____

Health Department Staff Use Only

Type Vaccine	Date Administered	Mfg. /Lot#/Exp. Date	Administration Route	Nurse Signature	Clerk initial/date entered in VHN
1st Intranasal: VFC /CP 2nd Intranasal: VFC/CP	1st _____ 2nd _____	1st _____ 2nd _____	Intranasal Intranasal	1st _____ 2nd _____	
1st Inactivated: VFC /CP 2nd Inactivated: VFC/CP	1st _____ 2nd _____	1st _____ 2nd _____	IM / LD/LM RD/RM IM / LD/LM RD/RM	1st _____ 2nd _____	
Allergy Status Verified	Right Vaccine / No Contra Indication	Right Formulation for Patient's Age	Right Patient / Verify @ Minimum Name & DOB	Right Dose / Route	Expiration Date Valid

Thomas County Health Departmnet

SOUTHWEST PUBLIC HEALTH DISTRICT

www.southwestgeorgiapublichealth.org

HIPAA Acknowledgement

Patient Name: _____ **Date of Birth**: _____

VHN #: _____ (Health Dept. will enter this number.)

HIPAA: Notice of Privacy Practices Acknowledgement

Patient Initial

_____I was given an opportunity to read the Notice of Privacy Practices for the Thomas County Board of Health, And to take my copy with me, if I so desire.

_____I wish to name one or more Personal Representatives. I understand that the Thomas County Board of Health is authorized to share my protected health information with a Personal Representative to assist with my care or treatment, payment for services I receive, and in situations where sharing my protected health information is vital to the day to day operations of the clinic. (List Personal Representatives below)

_____After reading the Notice of Privacy Practices, I wish to request restrictions on certain protected health information that the Thomas County Board of Health would normally share. I realize my request may be denied and that if it is denied, I will be notified in writing. (List requested restrictions below)

Personal Representatives:

_____

_____

Restrictions Requested:

_____

_____

Patient Signature: _____ **Date:** _____/_____/_____

This section for employee use only

I offered the patient a copy of the Thomas County Board of Health's Notice of Privacy Practices on the date listed below. The patient refused to sign the acknowledgement.

Signature: _____ Date: _____/_____/_____