Tennessee Department of Health School Located Influenza Vaccination Project
Student Consent Form and Influenza Immunization Documentation Form

If you want a Flu Vaccination given to your child, COMPLETE THE INFORMATION ON THE FRONT AND BACK OF THIS FORM AND SIGN.

PLEASE PRINT

School:_____ ***Home Room Teacher:***_____ ***Grade :***_____

Student: *Last Name*_____ *First Name:*_____ *MI :*_____

SEX: M F *DOB:* ____/____/____ *Current Age:*_____ *Child's SSN:* _____

RACE: ☐ *Asian* ☐ *Black* ☐ *Native American* ☐ *Pacific Islander* ☐ *White* ☐ *Other* ***ETHNICITY****: Hispanic* ***Y*** ***N***

Address:_____***City:***_____***State:***_____***Zip:***_____

Parent/Guardian: Last Name: _____ ***First Name:*** _____ ***MI:*** _____

Parent/Guardian Home Phone: ( )_____ ***Cell Phone: ( )***_____

ALL QUESTIONS MUST BE COMPLETED BY CHECKING YES OR NO IN ORDER FOR THE STUDENT TO RECEIVE A FLU VACCINE The Nurse giving the vaccination will review the information on vaccination day.	**YES**	**NO**
1. Has your child ever received a flu vaccine?		
2. Has your child received at least 2 seasonal Influenza (flu) vaccine doses in their lifetime? If unsure, mark No.		
3. Has your child ever had a severe (life threatening) allergic reaction to the flu vaccine requiring urgent medical attention?		
4. Does your child have severe (life threatening) allergy to eggs (requiring urgent medical attention? **If yes, describe:**		
5. Is your child allergic to vaccine components such as gentamicin, arginine, gelatin, MSG? **If yes, describe reaction:**		
6. Has your child ever had Guillain-Barre´ syndrome?		

Request for Administration of Influenza Vaccine for the above named recipient: I will receive information about the vaccine and special precautions on the Vaccine Information Sheet prior to my child receiving the vaccine and on the day of vaccination. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Tennessee Department of Health, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

I understand that this document will be given to and retained by the public health department. I give permission for my child's school to retain a copy if needed.
I acknowledge that I have been given the Department of Health's Notice of Privacy Practices.
I give consent to bill TennCare and/or private insurance for the service provided.

This Consent Form is valid for administration of influenza vaccinations for six (6) months. It may be used to administer a second dose of influenza vaccine, if needed. I understand that I should report any changes of the above information to the health department prior to vaccination.

_____ _____
Parent/Guardian Signature **Date**

PLEASE COMPLETE THE INFORMATION ON THE BACK OF THIS FORM

PARENTS: Please answer all questions below to provide necessary billing information and to determine if your child

might be eligible for the Vaccine for Children (VFC) program.

Does your child have CoverKids or any type of private medical insurance? If yes, please complete the insurance information below :

Name of Insurance Plan_____ Does insurance cover vaccines? YES NO

Policy Number:_____ Group Number:_____

Name of policyholder _____ Member ID:_____

Address To File Claims:_____ Birth Date of policy holder: _____
(*from back of card)*

Does your child have TennCare? If yes, circle the health plan and provide ID number:

BlueCare/TennCare Select United Health Care/Americhoice Amerigroup

TennCare ID#_____

Is your child uninsured? YES NO

Is your child an American Indian or Alaska Native? YES NO

. Nursing Immunization Documentation

AREA FOR OFFICIAL USE ONLY

VFC Eligible: YES NO

AREA FOR OFFICIAL USE ONLY

#1 Manufacturer: □ □ **Sanofi** □ □ **Seqirus** □ □ **GSK** □ □ **Other** _____

VIS Date: _____/_____/_____ **Site administered:** □ **Right Deltoid** □ **Left Deltoid**

Lot number: _____ **Signature**_____
Signature above indicates immunization given according to PHN Protocol

Date Given: _____ **Provider Number:** _____

#2 Manufacturer: □ **Sanofi** □ □ **Seqirus** □ **GSK** □ □ **Other**

VIS Date_____/_____/_____ **Site administered:** □**Right Deltoid** □ **Left Deltoid**

Lot number: _____ **Signature** _____
Signature above indicates immunization given according to PHN Protocol

Date Given: _____ **Provider Number:** _____