FLU VACCINE @SCHOOL CONSENT FORM:

AVAILABILITY OF FLU VACCINE WILL DETERMINE DATE GIVEN.

Student's Name: (First, Middle, Last):

_____

DOB: _____ SSN: _____ Age: _____ Gender: M F

Mailing Address: _____ City: _____ Zip: _____

Mother/Guardian: _____ Phone: _____

Father/Guardian: _____ Phone: _____

Primary Care Doctor/Clinic :_____ Town: _____ Pharmacy: _____

Is this patient covered by insurance? YES or NO Name of Insurance Company: _____
Ins. ID Number: _____ Group Number: _____Name of Subscriber: _____
Subscriber DOB: _____ Subscriber SSN: _____ Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: _____

Secondary Insurance Company: _____ Secondary Ins. ID Number:_____
Group Number: _____Name of Subscriber: _____Subscriber DOB: _____
Subscriber SSN: _____Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: _____

SCREENING QUESTIONS Please answer the following for the student/patient:

◯ NO ◯ YES Are you sick today? (vaccine will not be administered if patient is ill or has fever)

◯ NO ◯ YES Do you have allergies or reactions to any foods - including EGGS, medications, vaccines or latex?
If Yes, list: _____

◯ NO ◯ YES Females: are you pregnant or nursing?

◯ NO ◯ YES Have you received any vaccinations in the past 4 weeks?

◯ NO ◯ YES Do you have a history of asthma or wheezing?

◯ NO ◯ YES Are you receiving long-term aspirin therapy?

◯ NO ◯ YES Do you have a weakened immune system or close contact with a person with an extremely weakened immune system who needs special care?

◯ NO ◯ YES Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe:_____

◯ NO ◯ YES Have you ever fainted or passed out after an injection?

CONSENT:

I have read, or had explained to me, the attached Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccine be given to me (or the person named above for whom I am authorized to make this request). I authorize billing the insurance listed above and the release of any medical or other information necessary to process an insurance claim. I understand that RockPeds may disclose this health information to my Primary Care Provider listed above, health systems and hospitals, payment or other health care operations. I also understand that RockPeds will use and disclose my health information as set forth in the Notice of Privacy Practices, attached to this document.

Signature of Parent or Guardian Date

FOR CLINIC USE ONLY:

ADMINISTRATION DATE: _____

ENTERED IN ECW _____

ENTERED IN KY IMMUZ REGISTRY _____

STATE (VFC) OR PRIVATE

Callie Shaffer MD • Sarah Oliver MD • Courtney Browning APRN • Megan Taylor Pittman APRN • 140 Newcomb Avenue • Mt. Vernon KY 40456 •
(606) 256-4148 • Fax (606) 256-7785