Healthy Kids Clinic
A Part of Cumberland Family Medical Center, Inc.
PO Box 2399 · Russell Springs, KY 42642
Toll Free: 844.435.0900
www.healthykidsclinics.com

School: ______________________
Homeroom: __________________

FLU SHOT CONSENT FORM (Student)

Name: _______________________________________ Sex: _____ Allergies: ___________________________

Birthdate: _________ Language: ___________ Race: __________ Hispanic/Non-Hispanic: _____________

Address: ____ Zip Code: _____________

Phone Number: _____________________________ Social Security Number: __________________________

Insurance Company: _____________________ Policy Number: _____________________________________

Group #: __________________ Policy Holder Name: ____________________________ DOB: _____________

Relationship to Patient: __________ Address of Policyholder (if different than patient): _______________

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The FLU INJECTION is given in the muscle. Some conditions are precautions or contraindications to receive this vaccine. Please answer the following questions regarding your child:

•Do you have an allergy to eggs? ❑**Yes** ❑**No** If yes, what was the reaction? _______________________

• Do you have an allergy to Neomycin, Polymyxin, Kanamycin, or Gentamicin? ❑**Yes** ❑**No**

• Do you have a history of a severe allergic reaction to a flu vaccine? ❑**Yes** ❑**No**

• Do you have a history of Guillain-Barre' syndrome within 6 weeks following a previous flu vaccine?❑**Yes** ❑**No**

By signing this consent, I attest the above information is accurate and I consent for my student to receive the flu vaccine.

Parent/Guardian Signature: ____ Date: _______________

Office Use Only: Lot #:________________________ Exp. Date___________________
Manufacturer___________________ Date & Time Given______________________ VS: (T)_________
(P)_____________ (O2 sat)_______ Nurses Name:_____________ Inj. Site:_______