

School Name _____

If you do NOT want your child to receive flu vaccine, do NOT fill out or return form.

Section 1: Information About the Student Who Will Receive Influenza Vaccine (please print)

STUDENT'S FIRST NAME		MIDDLE INITIAL	(LAST NAME)		NICKNAME (Name student goes by at school)
DATE OF BIRTH (mm/dd/yyyy)		AGE	GENDER (Please check) ☐ Male ☐ Female		HOMEROOM TEACHER
ETHNICITY (Please Check) Hispanic/Latino ☐ Yes ☐ No		RACE (Please Check): ☐ African American/Black ☐ White ☐ Hispanic or Latino ☐ American Indian ☐ Asian ☐ Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other			PARENT/ LEGAL GUARDIAN'S NAME
HOME ADDRESS			PARENT/ GUARDIAN PHONE NUMBER(S)		
CITY		STATE	ZIP CODE		*Provide insurance plan information below.
INSURANCE INFORMATION: Does your child have Insurance that covers vaccines? ☐ Yes ☐ No If "Yes," please check health insurance provider below & complete the information to the right*:					Name of Policy Holder/Name on ID Card:
☐ Aetna ☐ Medicaid/PeachCare/Amerigroup/Peachstate/CareSource ☐ Ambetter ☐ United Healthcare ☐ Anthem BCBS ☐ UMR ☐ Cigna ☐ TRICARE Standard ONLY ☐ No Insurance ☐ CareSource Marketplace ☐ Other					Member ID#:
					Group#/Policy Type (HMO, PPO, CMO):
					Please attach a copy of the insurance card to this form.

Section 2: Medical Information: The following questions will help us to determine if this student can receive the influenza vaccine.

**Please check Yes or No for every 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 or Year		
3. Has the student ever had a serious allergic reaction to eggs?	Yes	No
4. Has the student ever had a serious reaction to any influenza (flu) 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 every day)	Yes	No
7. Does the student have any significant or chronic (long term) health conditions? (For example: diabetes, sickle cell disease, heart condition, lung condition, seizure disorder, cerebral palsy, muscle or nerve disorder, juvenile arthritis)	Yes	No
8. Does the student have a weak immune system? (For example, from HIV, cancer, or from taking medications such as steroids or those used to treat cancer?)	Yes	No
9. Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No
10. Adolescent females only: Is the student pregnant?	Yes	No
11. Is the person to be vaccinated receiving influenza antiviral medications?	Yes	No

Section 3: Consent to vaccinate

If this consent form is not filled out completely, signed, dated, and returned, the student will not be vaccinated at school.

CONSENT FOR STUDENT TO RECEIVE INFLUENZA VACCINE

By signing below, I acknowledge that the student and medical information provided above is correct. I have been given a copy of the VACCINE INFORMATION STATEMENT (VIS) for INFLUENZA VACCINE or a QR code to view the VIS for INFLUENZA VACCINE. 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. I understand that it is my responsibility to notify the school and the participating health department at least three business days prior to the school-based flu vaccination clinic event if my child has already received a flu vaccine by another provider this year.

By signing below, I give permission for the student listed above to receive flu vaccine.

Signature of Parent/Legal Guardian: _____ Date: _____

FOR CLINIC USE ONLY

Inactivated Influenza Vaccine 2026-27 Administration Route: ☐ IM / LEFT Deltoid ☐ IM / RIGHT Deltoid Vaccine Code: _____ Lot # _____ Exp Date: _____ Vaccine Administration Date: _____		Intranasal Influenza Vaccine 2026-27 Administration Route: ☐ Intranasal Vaccine Code: _____ Lot # _____ Exp Date: _____ Vaccine Administration Date: _____		 English Influenza (Flu) Vaccine Vaccine Information Statement
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Nurse Signature: _____ Date: _____ Entry Clerk Initial: _____ Date: _____

PUBLIC

\$PRIVATE\$



Bonzo Reddick, MD, MPH, District Health Director

802 Highway 119 South (PO Box 350)

Springfield, GA 31329

Phone: 912-754-6484 | Fax: 912-754-7623

Dear Parent/Guardian,

Ensuring the safety of our students from the influenza virus each year is important, and the best way to do that is to get them vaccinated. The Health Department will organize optional flu clinics in schools to assist with this goal. We are dedicated to ensuring a safe and streamlined process for all students, and every enrolled student will have the opportunity to receive the flu vaccine.

Please review the Vaccine Information Statement (VIS) about the flu vaccine. If you would like your student to be vaccinated at the school-based flu vaccination clinic, then you should complete, sign, and return the Parental Consent Form to your child's school as soon as possible. **If this consent form is not filled out completely, signed, dated, and returned before the event date, your student will not be vaccinated at the school-based clinic.** Additional copies of the consent form and VIS are available by going to www.coastalhealthdistrict.org and clicking on the "Immunizations and Vaccinations" link under the Quick Links menu on the home page.

All children are eligible to participate regardless of insurance status. We are asking for insurance information and a copy of your insurance card because we may be able to bill your insurance for the flu vaccine and a small administration fee to help support school-based flu clinics this year and in the future. If your insurance does not agree to pay the fee or you don't have insurance, you will not be billed by us or your insurance.

Please fully answer the medical questions on the consent form. Whether or not your child can receive the vaccine will be determined by the nurse based on your answers to the questions in the Parental Consent Form. If all questions are not answered, then the student will not be vaccinated at the school-based clinic. **It is your responsibility to notify the school and the participating health department at least three business days prior to the school-based flu vaccination clinic event if your child has already received a flu vaccine by another provider this year.**

The flu is easily spread through coughs and sneezes and by touching something with the virus and then touching your eyes, nose, or mouth. The flu vaccine is safe and effective and can help protect your child from illness, hospitalization, or worse.

Thank you, in advance, for helping us keep our students healthy. If you have any questions, please call the Effingham County Health Department at 912-754-6484.

Sincerely,

Bonzo Reddick, MD, MPH
District Health Director
Coastal Health District