Healthy Schools
Powered by CareDox

2018-2019 NO-COST Flu Shot (IIV*) Vaccine Consent Form

Complete this form and return it to your child's school.

PLEASE PRINT LEGIBLY WITH A BLUE OR BLACK PEN. EVERY SECTION OF THIS FORM IS REQUIRED.

Student Information					
Last Name	First Name, Middle Initial	Suffix	Name of School	Grade	Homeroom
Address			City	State	Zip Code

Birth Date (month/date/year)	Age	Sex	Demographic Information (Circle one): White American Indian/Native Alaskan Black Asian Hispanic Other

Parent/Guardian Information			
Last Name	First Name, Middle Initial	Suffix	Email Address
			Home Phone Number
Relationship to Student			Cell Phone Number

Required Health Insurance Information

We are required to bill your insurance company for the vaccine. There is NO COST to you. We guarantee you a $0 copay.

This program is made possible by parents accurately and honestly reporting their complete insurance information below. Thank you for your participation in this no-cost program.

Check one: ☐ Private Insurance ☐ Medicaid (ex: AmeriGroup, Wellcare, Integral)

☐ No Insurance: I certify that my child is not covered by any health insurance

Insurance Company	Member ID
Policy Holder's Name	Policy Holder's Date of Birth

Medical Information	**Check One**
Is your child 4 years or older?	☐ Yes ☐ No
Do any of the following apply to your child? (If you answer YES, your child cannot receive a Flu Vaccine at school, please contact your child's doctor) • Allergy to chicken eggs or egg products • Life threatening reaction(s) to flu vaccine in the past • Allergy to Latex • Has had Guillain-Barre syndrome (very rare)	☐ Yes ☐ No
Do any of the below apply to your child? Has long-term health problems with weakened immune system, heart disease, lung disease (e.g. cystic fibrosis), liver disease, kidney disease, or metabolic disorders (e.g. diabetes) or blood disorders (e.g. sickle disease or thalassemia)	☐ Yes ☐ No

If you have any questions, please contact your child's pediatrician or call Healthy Schools LLC at 1-800-566-0596 to speak to a nurse.

I have received, read, and understand the CDC Vaccine Information Statement for the Inactivated Influenza Vaccine (IIV). I have read these documents and understand the risk and benefits of the IIV vaccine. I give permission to Healthy Schools and their administrators to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Florida Department of Health policies. I hereby release Healthy Schools from any and all liability associated with the administration and potential side effects of the vaccine. I understand that my child and Healthy Schools will be creating a provider-patient relationship. By providing my cell phone I understand that I may be contacted at that number, including text messages, with information regarding Healthy School's services.

☐ **YES, I want my child to receive a no-cost, in-school flu shot.**

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____ Date _____

AREA FOR OFFICIAL USE ONLY		
VIS CDC IIV	IIVt0.5L IM Injection	
LOT Number	Expiration Date	
RN #	Date	Circle One: RUA LUA

*Inactivated Influenza Vaccine