Flu Vaccine Consent Form

HEALTH HERO
You Keep Them Smart
We Keep Them Healthy

School Name: **Clinic Date:**

PLEASE COMPLETE ALL OF THE INFORMATION BELOW - **Please print using ink** (Incomplete forms will not be accepted)

FIRST NAME of Student:	**LAST NAME of Student:**
Gender: Male Female **Birthdate: (mo,day,yr)**	**Age** **Homeroom Teacher / Grade**
Address	**Home Phone # ( ) -** **Cell Phone # ( ) -**
City **Zip Code** **State**	**Student Race:** (Circle one) African American / Black White Alaskan/ Native American Asian Hispanic Non-Hispanic Hawaiian / Pacific Islander Other :
Email address:	

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.

Please fill out the following questions pertaining to your child's Health Insurance:

Medicaid ☐ **My child does NOT have health insurance** ☐	**Insurance Company:**
Policy Holder's First Name:	**Policy Holder's Last Name:**
Member ID:	**Policy Holder's Date of Birth: (mo,day,yr)**

CHECK YES OR NO FOR **EACH** QUESTION

YES	NO	
☐	☐	1. Has your child ever had a life threatening reaction(s) to the flu vaccine in the past?
☐	☐	2. Has your child ever had Guillain-Barre' syndrome?
☐	☐	3. Does your child have an allergy to eggs?
☐	☐	4. Does your child have a blood disorder such as hemophilia?
☐	☐	5. Will this be the first time your child has ever received a flu vaccination?
☐	☐	6. If available next year, would you prefer to have Flumist ?

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL US AT 205-609-0268 TO SPEAK TO A REPRESENTATIVE.

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release the school system, HNH Immunizations, Inc. & subsidiaries, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. Clinic dates can be obtained from the school. I understand that the health related information on this form will be used for insurance billing purposes and your privacy will be protected.

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

VIS CDC IIV 08/15/2019 FLUCELVAX
LOT Number: **EXP Date:**
RN #_____ Date:_____
AREA FOR OFFICIAL ADMINSTRATION USE ONLY

HNH Immunizations Inc.
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Union Springs, AL 36089
AL@healthherousa.com
205-609-0268

IMMUNIZATIONS HNH INCORPORATED