2023-24 School Based Influenza Vaccine Consent Form
Greene County Health Department

Section 1: Information about Student to Receive Influenza Vaccine (please print)

STUDENT'S NAME (Last) If applicable, Suffix	(First)	(M.I.)	PREFERRED FIRST NAME	SCHOOL NAME:
STUDENT'S DATE OF BIRTH (mm/dd/yyyy)	STUDENT'S AGE	GENDER: Male Female	TEACHER	GRADE
ETHNICITY *(Please Circle)* Not Hispanic/Latino Hispanic Latino	RACE *(Please Circle)* African American, White, Hispanic or Latino, American Indian, Asian, Alaska Native, Native Hawaiian, Other Pacific Islander, Multi-racial		PARENT/ LEGAL GUARDIAN'S NAME	
STUDENT'S HOME MAILING ADDRESS			COUNTY OF RESIDENCE	
PHYSICAL ADDRESS (If different from mailing address)			PARENTAL/ GUARDIAN PHONE NUMBER (home, mobile, work)	
CITY STATE		ZIP CODE	PARENTAL/ GUARDIAN E-MAIL (personal, work)	

INSURANCE INFORMATION: Do you have insurance that covers vaccines?

☐ Yes, patient has insurance coverage; **Please check insurance below:**

- ☐ Aetna
- ☐ Ambetter
- ☐ Anthem BCBS
- ☐ CareSource ACA
- ☐ Medicaid ***includes*** (Amerigroup, CareSource, or Peach State)
- ☐ CHAMPVA
- ☐ CIGNA
- ☐ Humana
- ☐ First Health Plans
- ☐ PeachCare
- ☐ United Healthcare
- ☐ Medicare
- ☐ Tricare East/Life

☐ **Other insurance not listed above:** _____

☐ **No, student does not have insurance**

Mother's Maiden Name for student required by GRITS

Provide the insurance information & attach a copy of the insurance card to this form *if possible*

Policy Holder Name _____

Member ID # _____

Group # _____

Payer ID or EDI Number: _____

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

Please circle Yes or No for each 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 influenza?	DATE:	
3. Does the student to be vaccinated have an allergy to an ingredient of the vaccine?	Yes	No
4. Has the student to be vaccinated ever had a serious reaction to influenza vaccine in the past?	Yes	No
5. Has the student to be vaccinated ever had Guillain Barré syndrome?	Yes	No
6. Has the student to be vaccinated ever felt dizzy or faint before, during, or after a shot?	Yes	No

Section 3: Consent: *If this consent form is not filled in completely, signed, dated, and returned, the student will not be vaccinated at school.*

I GIVE CONSENT to the Greene County Health Department for the student named above to receive the influenza vaccine. I acknowledge that the student and medical information provided above is correct. I have been given a copy of and have read (or have had explained to me) the information in the Vaccine Information Statement (VIS) for the influenza vaccine. I have had a chance to ask questions and they were answered to my satisfaction. I believe that I understand the benefits and risks of the influenza vaccine. I ask that the influenza vaccine be given to the student named above for whom I am authorized to make this request.

HIPAA: By signing this form, you acknowledge you have seen and have been offered a copy of the Notice of Privacy Practices from this County Health Department and that you have provided accurate contact information and preferences or have specified that you do not want to be contacted.

Signature of Parent/Legal Guardian: _____ ***Date:*** _____

FOR CLINIC USE ONLY

Student's Name: _____

DOB: _____

Client ID #: _____

FOR CLINIC USE ONLY						
Influenza (IIV4, ccIIV4, LAIV4)	**Site & Route**	**Date Dose Administered**	**Mfg Trade Name**	**Lot #**	**Exp Date**	**VIS Date**
☐ Quadrivalent (IIV4) **FV4P** .5 syr NonSt **FV4V** .5 syr StSupl For 6m – 18 years	LVL/IM LD/IM RVL/IM RD/IM	/ /	GSK **Fluarix** Quad GSK **FluLaval** Quad Sanofi Pasteur **Fluzone** Quad		/ /	8/6/2021
☐ Quadrivalent (ccIIV4) **FCC4P .5** syr NonSt **FCC4V** .5 syr StSupl For 6m – 18 years	LVL/IM LD/IM RVL/IM RD/IM	/ /	Seqirus **Flucelvax** Quad		/ /	8/6/2021
☐ FluMist Quad (LAIV4) **FI4P** .2 spray NonSt **FI4V** .2 spray StSupl For 2 – 18 years	Nose – Intranasal	/ /	MedImmune **FluMist** Quad		/ /	8/6/2021

Signature of Nurse: _____ **Date:** _____

Entry Clerk Name: _____ **Date:** _____