Flu Vaccine Consent Form

HEALTH HERO — You Keep Them Smart We Keep Them Healthy

School Name: **Clinic Date:**

FIRST NAME of Student:		**LAST NAME of Student:**	
Gender: Male Female	**Birthdate: (MM/DD/YYYY)**	**Age**	**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: (MM/DD/YYYY)**

CHECK YES OR NO FOR **EACH** QUESTION

1	Has the person to be vaccinated ever had a severe or life threatening reaction to the flu vaccine?	YES	NO
2	Has the person to be vaccinated ever had Guillain-Barre syndrome?	YES	NO
3	Does the patient have an allergy to eggs?	YES	NO
4	Does the patient have an allergy to any component of the vaccine?	YES	NO

ONLY RETURN THIS FORM IF YOU WANT THIS VACCINE

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 hereby acknowledge that based on the information presented to me, my child is eligible to receive the influenza vaccine on this date. I request and voluntarily consent for the vaccine to be given to the child listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I understand that no assurance can be given that the influenza vaccination will give immunity from contracting any strain of influenza. My child is feeling well today and he/she has not recently had a fever. I accept responsibility for seeking medical attention for any problems associated with receiving the vaccine. I hereby release the school system, Health Hero America LLC, its employees, representatives and agents from any liability for giving the influenza vaccination to my child. I understand this consent is valid for 6 months and that I will make the school aware of any changes in my child's health prior to the vaccination clinic date. Clinic dates can be obtained from the school. I authorize HHA to provide my child's school with documentation of vaccinations given today.

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

HHA Staff Signature _____ Date _____

AREA FOR OFFICIAL ADMINSTRATION USE ONLY

VIS CDC IIV 08/15/2019 FLUZONE

Administered by: _____ Location: RA LA

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HEALTH HEROES