**ATTENTION PARENTS: GO TO http://knoxcounty.org/health/flumist FOR THE ONLINE CONSENT FORM** Or, if you don't want to complete the consent process on-line, please complete this form and return it to your child's homeroom teacher. **Please do not do both.**

**KCHD STUDENT INFLUENZA CONSENT FORM**
**Immunization Nursing Record - SLVC 2014**

| **Official Use Only** | **Vaccine Source:** VFC KCHD<br>**Vaccine Naïve**: No Yes<br>**Vaccine Type:** IIV: 6-35m 36m+ LAIV |
|---|---|

**PLEASE PRINT** Age: ____ DOB: ____/____/_____ SS# _____

School: _____ Home Room Teacher: _____ Grade: _____

Student's Name - First: _____ MI: ____ Last: _____

Address: _____ City:_____ Zip Code:_____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____ Emergency Number: ( ) _____-_____

Email:_____ Child's Pediatrician:_____

Mother's Name:_____ Father's Name:_____

OR Guardian, if it applies- Name: _____ Relationship:_____

Gender: ☐ Male ☐ Female Primary Language: _____ Hispanic: ☐ Yes ☐ No

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Other:_____

Insurance: ☐ TennCare ☐ No Insurance ☐ Private Insurance ☐ Private Insurance (but does not cover flu)

Primary Insurance Name: _____ Member ID: _____ Group ID: _____

Insurance Address: _____

Subscriber Name: _____ Subscriber DOB_____

Secondary Insurance Name: _____ Member ID: _____ Group ID: _____

Insurance Address: _____

Subscriber Name: _____ Subscriber DOB_____

| **Please answer YES or NO to all questions below. Answers are for the person receiving the vaccine.** | **Circle** for each question | |
|---|---|---|
| 1. Has your child received at least 2 doses of FLU vaccine since July 2010? If unsure, mark No. | **Yes** | **No** |
| 2. Has your child received a vaccine within the past 30 days? Name of Vaccine(s): Date(s): | **Yes** | **No** |
| 3. Has your child ever had a severe (life threatening) allergic reaction to the flu vaccine such as wheezing or hives? | **Yes** | **No** |
| 4. Does your child have any of the following:<br>- chronic heart diseases - diabetes or other metabolic diseases/disorders - blood diseases<br>- asthma/reactive airway disease/wheezing - an inhaler that is used regularly - kidney diseases<br>**If yes,** please describe: | **Yes** | **No** |
| 5. Is your child allergic to vaccine components such as eggs, gentamicin, arginine, gelatin, MSG?<br>**If yes,** describe reaction: | **Yes** | **No** |
| 6. Is your child pregnant? | **Yes** | **No** |
| 7. Has your child ever had Guillain-Barre´ syndrome? | **Yes** | **No** |
| 8. Is your child on long-term aspirin therapy or taking Tamiflu®, Relenza®, amantadine, or rimantadine? | **Yes** | **No** |
| 9. Does your child have a disease such as cancer, lupus, HIV/AIDS, or take a medication that lowers the body's resistance to infection? | **Yes** | **No** |
| 10. Does your child have close contact with anyone who has had a bone marrow transplant in the last 6 months? | **Yes** | **No** |

**Consent for Administration of Influenza Vaccine for the above named recipient**: I am aware that the receiver of this vaccine is currently not pregnant nor will become pregnant within four weeks of receiving this vaccine. I have read information about the vaccine and special precautions on the Vaccine Information Sheet. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Knox County Government, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination. This consent gives Knox County Health Department permission to file rendered services to your insurance carrier. Consent form is valid 6 months from date of initial signature.

Parent / Guardian Signature _____ Date _____

**PARENT COMMENTS:**

**OFFICIAL USE ONLY**

VFC KCHD IIV LAIV

**PHASE ONE**
Mfr/Lot:_____ NDC#: _____ Expiration: _____ Amount: _____ Date Given: _____
VIS Date:_____ Route: _____ Site: _____ Signature: _____ Provider ID: _____

VFC KCHD IIV LAIV

**PHASE TWO**
Mfr/Lot:_____ NDC#: _____ Expiration: _____ Amount: _____Date Given: _____
VIS Date:_____ Route: _____ Site: _____ Signature: _____ Provider ID: _____