

If you want your student vaccinated for the FLU, complete and return this form to your child's homeroom teacher or you can fill it out online at <http://knoxcounty.org/health/schoolflu>. If you **do not** want your child vaccinated, **do not** fill out either form.

7/31/18



## 2018 Student FLU Vaccine Consent Form

**PLEASE PRINT - All fields are required**

<b>Official Use Only</b>	<b>Vaccine Source:</b> VFC    KCHD	
	<b>Vaccine Naïve:</b> No        Yes	
	<b>Vaccine Type:</b> IIV: 6-35m    36m+    LAIV	
	Phase 1	Phase 2

Student's Name - First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

School: \_\_\_\_\_ Home Room Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Gender:  Male  Female    Hispanic:  Yes  No    Primary Language: \_\_\_\_\_

Race:  White  Black  Asian  American Indian  Alaskan Native  Other: \_\_\_\_\_

**Primary Insurance (Select One):**     CoverKids     TennCare     Private Insurance     No Insurance

Primary Insurance Name: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Insurance Address/P.O. Box: \_\_\_\_\_ Insurance ZIP Code: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**Secondary Insurance (Select One):**     CoverKids     TennCare     Private Insurance     No Secondary Insurance

Secondary Insurance Name: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Insurance Address/P.O. Box: \_\_\_\_\_ Insurance ZIP Code: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**Please Circle YES or No for all questions. Answers are for the person getting the vaccine.**

1. Has your child had at least 2 doses of FLU vaccine during his or her lifetime? If unsure, mark No.	Yes	No
2. Has your child had a vaccine for MMR, Varicella (Chicken Pox), or Yellow Fever within the past 30 days? <b>Name of Vaccine(s):</b> _____ <b>Date(s):</b> _____	Yes	No
3. Has your child ever had a severe or life threatening allergic reaction to the flu vaccine such as wheezing or breathing problems? <b>If yes, describe reaction:</b> _____	Yes	No
4. Is your child allergic to vaccine components such as eggs, gentamicin, arginine, gelatin, or MSG? <b>If yes, describe reaction:</b> _____	Yes	No
5. Has your child ever been diagnosed with Guillain-Barre´ syndrome?	Yes	No
6. Does your child have any of the following: -chronic heart diseases                                      -diabetes or other metabolic diseases/disorders                                      -blood diseases -asthma/reactive airway disease/wheezing                                      -an inhaler that is used regularly                                      -kidney diseases -cancer, lupus or HIV/AIDS                                      -a medication that lowers the body's resistance to infection	Yes	No
7. Is your child pregnant?	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 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 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. **For a copy of the Vaccine Information Sheet visit [http://www.immunize.org/vis/flu\\_live.pdf](http://www.immunize.org/vis/flu_live.pdf).**

**PARENT COMMENTS:**

Parent /Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Primary Phone: (      ) \_\_\_\_\_ - \_\_\_\_\_      Emergency Number: (      ) \_\_\_\_\_ - \_\_\_\_\_

**Official Use Only**  
Place **Phase 1** Nursing  
Record Sticker Here  
Align with right side of this box

**Official Use Only**  
Place **Phase 2** Nursing  
Record Sticker Here  
Align with left side of this box