



2017 STUDENT FLU SHOT CONSENT FORM

PLEASE PRINT - All fields are required

Official Use Only	Vaccine Source: VFC <input type="checkbox"/> KCHD <input type="checkbox"/>
	Vaccine Naïve: No <input type="checkbox"/> Yes <input type="checkbox"/>
	Vaccine Type: IIV: 6-35m <input type="checkbox"/> 36m+ <input type="checkbox"/> 48m+ <input type="checkbox"/>
Phase 1 <input type="checkbox"/> Phase 2 <input type="checkbox"/>	

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

Age: _____ DOB: ____/____/____ SS#: _____-____-_____

School: _____ First Block Teacher: _____ Grade: _____

Home Address: _____ ZIP Code: _____

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

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 answer YES or NO to all questions. Answers are for the person receiving the vaccine.

Circle for each question

**** This flu vaccine is a shot ****

1. Has your child received at least 2 doses of FLU vaccine during his or her lifetime? If unsure, mark No.	Yes	No
2. Has your child ever had a severe or life threatening allergic reaction to the flu vaccine such as wheezing or breathing problems? If yes, describe reaction:	Yes	No
3. Is your child allergic to eggs? If yes, describe reaction:	Yes	No
4. Has your child ever had Guillain-Barre´ syndrome?	Yes	No
5. Does your child faint when they get a shot?	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_inactive.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