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. 5/4/17

Knox Hoolth
county Health
Donontmont
Department
Every Person,
A III - III - Dans

2017 STUDENT FLU SHOT CONSENT FORM PLEASE PRINT - All fields are required

-					ħ
Official	Vaccine Source	: VFC	KCHD		
Use	Vaccine Naïve:	No	Υe	es 🗀	
Only	Vaccine Type:	IIV: 6-35m	36m+	48m	1+

Student's Name - First:	A Healthy Person	-	_ 011119	vaccine Type	. IIV. 0-33III 3	JIIIT	1 01111+
School: Home Room Teacher: Grade: ZIP Code: Home Address: ZIP Code: ZIP Code: Sender: 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 ZIP Code: Subscriber Name: Relationship to Student: Subscriber DOB: Secondary Insurance (Select One): CoverKids TennCare Private Insurance No Secondary Insurance ZIP Code: Subscriber Name: Relationship to Student: Subscriber DOB: Secondary Insurance (Select One): CoverKids TennCare Private Insurance No Secondary Insurance Name: Member ID: Group ID: Insurance ZIP Code: Subscriber Name: Relationship to Student: Subscriber DOB: Subscriber Name: Relationship to Student: Subscriber Pools: Subscriber DOB: Subscriber Name: Relationship to Student: Subscriber DOB: Subscriber Name: Relationship to Student: Subscriber DOB: Subscriber Name: Relationship to Student:	Student's Name - First:	MI: Last	:			Phase	1 Phase
Home Address:	Age: DOB:/ SS#:						
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/PO. Box: Insurance Address/PO. Box: Insurance ZIP Code: Subscriber Name: Relationship to Student: Subscriber DOB: Secondary Insurance (Select One): CoverKids TennCare Private Insurance No Secondary Insurance Name: Member ID: Group ID: Insurance Address/PO. Box: Insurance Name: Member ID: Group ID: Insurance Address/PO. 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. ** 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. If yes, describe reaction: 3. Is your child allergic to eggs? If yes, describe reaction: 4. Has your child allergic to eggs? If yes, describe reaction: 5. Does your child faint when they get a shot? Consent for Administration of Influenza Vaccine for the above named recipient: I have read information about the vaccine and special precautions on the Vaccinosent during this parent or legal guardian, and acknowledge that necessary so which arises during vaccines begin to the person advoluntarily consent that the vaccine be gin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advo	School:	Home Room Tea	cher:		Grade:		
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/PO. Box: Insurance Address/PO. Box: Insurance ZIP Code: Subscriber Name: Relationship to Student: Subscriber DOB: Secondary Insurance (Select One): CoverKids TennCare Private Insurance No Secondary Insurance Name: Member ID: Group ID: Insurance Address/PO. Box: Insurance Name: Member ID: Group ID: Insurance Address/PO. 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. ** 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. If yes, describe reaction: 3. Is your child allergic to eggs? If yes, describe reaction: 4. Has your child allergic to eggs? If yes, describe reaction: 5. Does your child faint when they get a shot? Consent for Administration of Influenza Vaccine for the above named recipient: I have read information about the vaccine and special precautions on the Vaccinosent during this parent or legal guardian, and acknowledge that necessary so which arises during vaccines begin to the person advoluntarily consent that the vaccine be gin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advoluntarily consent that the vaccine begin to the person advo	Home Address:				ZIP Code	e:	
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 ZIP Code: Subscriber Name: Relationship to Student: Subscriber DOB: Secondary Insurance (Select One): CoverKids TennCare Private Insurance DN Secondary Insurance Secondary Insurance Name: Member ID: Group ID: Insurance ZIP Code: Subscriber Name: Member ID: Group ID: 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. ** 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. 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: 3. Is your child allergic to eggs? If yes, describe reaction: 4. Has your child ever had Guillain-Barre' syndrome? 5. Does your child faint when they get a shot? Consent for Administration of Influenza Vaccine for the above named recipient: I have read information about the vaccine and special precautions on the Vaccine they end advanced before the above of whom I am parent or legal quardian, and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release 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 COMMENTS:		_			-		
Insurance Address/P.O. Box:	Primary Insurance (Select One):	verKids	Priva	te Insurance	No Insurance	Э	
Subscriber Name:	Primary Insurance Name:	Memb	oer ID:	G	roup ID:		
Secondary Insurance (Select One): CoverKids TennCare Private Insurance No Secondary Insurance Secondary Insurance Member ID: Group ID: Insurance Address/P.O. Box: 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. ** 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. 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: 3. Is your child allergic to eggs? If yes, describe reaction: 4. Has your child faint when they get a shot? Consent for Administration of Influenza Vaccine for the above named recipient: I have read information about the vaccine and special precautions on the Vaccinformation 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 git 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 Krox Courdy Health Department permission to file rendered services to your insurance carrier. Consent form is valid 6 months from date of initial signate. PARENT COMMENTS:	Insurance Address/P.O. Box:			In	surance ZIP Cod	de:	
Secondary Insurance Name:	Subscriber Name:	Relationship to Stud	ent:	S	Subscriber DOB:		
Relationship to Student: Subscriber Name: Relationship to Student: Subscriber DOB: Please answer YES or NO to all questions. Answers are for the person receiving the vaccine. ** 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. 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: 3. Is your child allergic to eggs? If yes, describe reaction: 4. Has your child ever had Guillain-Barrer syndrome? 5. Does your child faint when they get a shot? Consent for Administration of Influenza Vaccine for the above named recipient: I have read information about the vaccine and special precautions on the Vaccinotime to 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 Health Department permission to file rendered services to your insurance carrier. Consent form is valid 6 months from date of initial signature of the Vaccine Information Sheet visit http://www.immunize.org/vis/flu_inactive.pdf. PARENT COMMENTS:	Secondary Insurance (Select One):	verKids	☐ Priva	te Insurance	☐ No Seconda	ry Insur	ance
Please answer YES or NO to all questions. Answers are for the person receiving the vaccine. ** 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. 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: 3. Is your child allergic to eggs? If yes, describe reaction: 4. Has your child ever had Guillain-Barre' syndrome? 5. Does your child faint when they get a shot? Consent for Administration of Influenza Vaccine for the above named recipient: I have read information about the vaccine and special precautions on the Vaccine for the person receiving the vaccine so use success. 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 guarantee and econcerning the vaccine's success. I hereby release knox Cou 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. To 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 COMMENTS:	Secondary Insurance Name:	Membe	er ID:	G	roup ID:		
Please answer YES or NO to all questions. Answers are for the person receiving the vaccine. ** 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. 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: 3. Is your child allergic to eggs? If yes, describe reaction: 4. Has your child ever had Guillain-Barre' syndrome? 5. Does your child faint when they get a shot? Consent for Administration of Influenza Vaccine for the above named recipient: I have read information about the vaccine and special precautions on the Vaccine for the person receiving the vaccine so use success. 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 guarantee and econcerning the vaccine's success. I hereby release knox Cou 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. To 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 COMMENTS:	Insurance Address/P.O. Box:			Ir	nsurance ZIP Co	de:	
Please answer YES or N0 to all questions. Answers are for the person receiving the vaccine. ** 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. 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: 3. Is your child allergic to eggs? If yes, describe reaction: 4. Has your child ever had Guillain-Barre´ syndrome? 5. Does your child faint when they get a shot? Consent for Administration of Influenza Vaccine for the above named recipient: I have read information about the vaccine and special precautions on the Vaccine for the 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 Coulogovernment, their affiliates, employees, directors and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination. Teora copy of the Vaccine Information Sheet visit http://www.immunize.org/vis/flu_inactive.pdf. PARENT COMMENTS:							
1. Has your child received at least 2 doses of FLU vaccine during his or her lifetime? If unsure, mark 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: 3. Is your child allergic to eggs? If yes, describe reaction: 4. Has your child ever had Guillain-Barre´ syndrome? 5. Does your child faint when they get a shot? Consent for Administration of Influenza Vaccine for the above named recipient: I have read information about the vaccine and special precautions on the Vaccinformation 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 Cou 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. T 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:			-	n receiving t	he vaccine.	Circ each c	le for uestion
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: 3. Is your child allergic to eggs? If yes, describe reaction: 4. Has your child ever had Guillain-Barre´ syndrome? 5. Does your child faint when they get a shot? Consent for Administration of Influenza Vaccine for the above named recipient: I have read information about the vaccine and special precautions on the Vaccine for Administration 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 Cou 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. To 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 or a copy of the Vaccine Information Sheet visit http://www.immunize.org/vis/flu_inactive.pdf. PARENT COMMENTS:				unquiro, mark No		Yes	No
If yes, describe reaction: 4. Has your child ever had Guillain-Barre' syndrome? 5. Does your child faint when they get a shot? 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 Cou 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. To 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:	2. Has your child ever had a severe or life threat problems?	ening allergic reaction to the	e flu vaccine	such as wheezir	g or breathing	Yes	No
4. Has your child ever had Guillain-Barre syndrome? 5. Does your child faint when they get a shot? Consent for Administration of Influenza Vaccine for the above named recipient: I have read information about the vaccine and special precautions on the Vaccine for 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 Cou 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. To 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 COMMENTS:						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 Cou 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. To 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:	Has your child ever had Guillain-Barre' syndro	ome?				Yes	No
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 Cou 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. To 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 of the Vaccine Information Sheet visit http://www.immunize.org/vis/flu_inactive.pdf. PARENT COMMENTS:	5. Does your child faint when they get a shot?					Yes	No
Parent /Guardian Signature: Date:	Information Sheet. I have had an opportunity to ask questions re to the person above of whom I am parent or legal guardian, and Government, their affiliates, employees, directors and officers fr consent gives Knox County Health Department permission to For a copy of the Vaccine Information Sheet visit http://www.	egarding the vaccine and understan d acknowledge that no guarantees rom any and all liability arising from o file rendered services to your ir	d the risks and thave been made any accident, ac asurance carrier	penefits. I request and e concerning the vacc et of omission or comm	voluntarily consent that ine's success. I hereby hission, which arises du	the vaccine release Kno ring vaccina	be given ox County ition. This
	Parent /Guardian Signature:			Date:			

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

Parent/Guardian Name: _

Primary Phone: (

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

Relationship to Student: ___

Emergency Number: (