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

county Health
Department
Every Person, A Healthy Person

## 2018 Student FLU Vaccine Consent Form PLEASE PRINT - All fields are required

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

PLEASE PRINT - All fields are required	Only	Vaccine Type:	IIV: 6-35m	36m+	LAIV
Student's Name - First: MI: MI: La	st:			Phase '	1 Phase
Age: DOB:/ SS#:					
School: Home Room Te			Grade:		
Home Address:					
Gender: Male Female Hispanic: Yes No					
Race: White Black Asian American Indian Ala	-				
Primary Insurance (Select One): CoverKids TennCar	re  Privat	e Insurance	No Insura	nce	
Primary Insurance Name: Mer	mber ID:	Gro	oup ID:		
Insurance Address/P.O. Box:					
Subscriber Name: Relationship to Stu					
Secondary Insurance (Select One): CoverKids TennCar		_			
Secondary Insurance Name: Mem				-	
Insurance Address/P.O. Box:			surance ZIP (		
Subscriber Name: Relationship to Stu					
Please Circle YES or No for <u>all</u> questions. Answers are	•		ie vaccine.	Yes	No
<ol> <li>Has your child had at least 2 doses of FLU vaccine during his or her lifetime? If unsure, mark No.</li> <li>Has your child had a vaccine for MMR, Varicella (Chicken Pox), or Yellow Fever within the past 30 days?</li> </ol>					No
Name of Vaccine(s):  3. Has your child ever had a severe or life threatening allergic reaction to	Date( the flu vaccine		or breathing	Yes	No
problems? If yes, describe reaction:				163	- 140
4. Is your child allergic to vaccine components such as eggs, gentamicin, <b>If yes,</b> describe reaction:	arginine, gelati	n, or MSG?		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 -asthma/reactive airway disease/wheezing -cancer, lupus or HIV/AIDS -diabetes or other metaboran inhaler that is used recancer, lupus or HIV/AIDS -a medication that lowers	gularly	-k	lood diseases idney diseases	163	No
7. Is your child pregnant?	the body o rook			Yes	No
8. Is your child on long-term aspirin therapy or taking Tamiflu®, Relenza®, amantadine, or rimantadine?					No
Does your child have close contact with anyone who has had a bone marrow transplant in the last 6 months?					No
Consent for Administration of Influenza Vaccine for the above named recipier Information Sheet. I have had an opportunity to ask questions regarding the vaccine and underst to the person above of whom I am parent or legal guardian, and acknowledge that no guarantee Government, their affiliates, employees, directors and officers from any and all liability arising froconsent gives Knox County Health Department permission to file rendered services to your For a copy of the Vaccine Information Sheet visit http://www.immunize.org/vis/flu_live.pdPARENT COMMENTS:	tand the risks and bes have been made om any accident, acting insurance carrier.	enefits. I request and v concerning the vaccin of omission or commis	oluntarily consent to e's success. I here ssion, which arises	that the vaccine eby release Kno during vaccina	e be given ox County ation. This
Parent /Guardian Signature:		Date:			
		Student:			
		r: ( )			

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