Tennessee Department of Health School Located Influenza Vaccination Project
Student Consent Form and Influenza Immunization Documentation Form

If you want a Flu Vaccination given to your child, COMPLETE THE INFORMATION ON THE FRONT AND BACK OF THIS FORM AND SIGN. ***IF NO, stop here and discard the form.***

PLEASE PRINT

School:_______________________ ***Home Room Teacher:***_______________________ ***Grade :***__________

Student: *Last Name*_______________________ *First Name:*_______________________ *MI :*__________

SEX: M F *DOB:*____/____/____ *Current Age:*________ *Child's SSN:* _______________________

RACE: *Asian* *Black* *Native American* *Pacific Islander* *White* *Other* ***ETHNICITY****: Hispanic* ***Y*** ***N***

Address:_______________________ ***City:***_______________________ ***State:***________ ***Zip:***__________

Parent/Guardian: Last Name:_______________________ ***First Name:***_______________________ ***MI:***

Parent/Guardian Home Phone: (____)_______________________ ***Cell Phone: (____)***_______________________

ALL QUESTIONS MUST BE COMPLETED BY CHECKING YES OR NO IN ORDER FOR THE STUDENT TO RECEIVE A FLU VACCINE **The Nurse giving the vaccination will review the information on vaccination day.**	**YES**	**NO**
1. Has your child ever received a flu vaccine? When?		
2. Has your child received at least 2 seasonal Influenza (flu) vaccine doses since July 2010?		
3. Has your child ever had a serious reaction to the flu vaccine in the past? If yes, please explain.		
4. Does your child have any allergies to food or medicine? If yes, please list.		
5. Does your child have an allergy to any components of the flu vaccine?		
6. Has your child ever had Guillain-Barre´ syndrome?		
7. Has your child received any other vaccinations in the past 4 weeks? Name of Vaccine(s): Where: Date Given:		
8. In the past 12 months, has a healthcare provider told you that your child had wheezing or asthma? (If yes, the live virus vaccine is not recommended for children ages 2 through 4 years)		
9. Does your child have a long term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?		
10. Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
11. In the past 3 months, has your child taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or have they had radiation treatments?		
12. Does your child live with or expect to have close contact with a person whose immune system is severely compromised so they have to live in a protective environment, such as an isolation ward for a bone marrow transplant?		
13. Is your child or teen (2 years through 17 years of age) receiving aspirin therapy or aspirin containing therapy?		
14. Is your child receiving any prescription medications to prevent or treat flu? If yes please list:		
15. Is your child pregnant or does she expect to be pregnant within the next month?		

Additional Notes:

Request for Administration of Influenza Vaccine for the above named recipient: I will receive information about the vaccine and special precautions on the Vaccine Information Sheet prior to my child receiving the vaccine and on the day of vaccination. 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 Tennessee Department of Health, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

I understand that this document will be given to and retained by the public health department. I give permission for my child's school to retain a copy if needed.
I acknowledge that I have been given the Department of Health's Notice of Privacy Practices.
I give consent to bill TennCare and/or private insurance for the service provided.
This Consent Form is valid for administration of influenza vaccinations for six (6) months. It may be used to administer a second dose of influenza vaccine, if needed. I understand that I should report any changes of the above information to the health department prior to vaccination.

Parent/Guardian Signature **Date**

PLEASE COMPLETE BACK OF FORM

PARENTS: Please answer questions below for all students under age 19 yrs to determine if your child might be eligible for the Vaccine for Children (VFC) program.

Does your child have CoverKids or any type of private medical insurance? If yes, please complete the insurance information below :

Name of Insurance Plan____________________________________ Does insurance cover vaccines? YES NO

Policy Number:____ Group Number:____________________________________

Name of Subscriber: ______________________________________ Member ID:_______________________________________

Address To File Claims:____________________________________ Birth Date of Subscriber: __________________________
(from back of card)

Does your child have TennCare? If yes, circle the health plan and provide ID number:

BlueCare/TennCare Select United Health Care Amerigroup

TennCare ID#____

If your child has private insurance and TennCare, please complete private insurance information above also.

Is your child uninsured?
YES NO

Is your child an American Indian or Alaska Native?
YES NO

. **Nursing Immunization Documentation**

AREA FOR OFFICIAL USE ONLY

VFC Eligible: YES NO

AREA FOR OFFICIAL USE ONLY

#1 Manufacturer: ☐ **Sanofi** ☐ **Seqirus** ☐ **GSK** ☐ **AstraZeneca** ☐ **Other** ______________________________

VIS Date: ______/______/_______ **Site administered:** ☐ **Right Deltoid** ☐ **Left Deltoid** ☐ **Intrasnasal**

Lot number: ___________________ **Signature**____
Signature above indicates immunization given according to ***PHN Protocol***

Date Given: ___________________ **Provider Number:** ____

#2 Manufacturer: ☐ **Sanofi** ↑ ☐ **Seqirus** ☐ **GSK** ↑ ☐ **AstraZeneca** ☐ **Other** ________________________

VIS Date______/_______/_______ **Site administered:** ☐ **Right Deltoid** ☐ **Left Deltoid** ☐ **Intrasnasal**

Lot number: ___________________ **Signature** ____
S*ignature above indicates immunization given according to* ***PHN Protocol***

Date Given: ___________________ **Provider Number:** ____