## FLU VACCINE @SCHOOL CONSENT FORM:

**AVAILABILITY OF FLU VACCINE WILL DETERMINE DATE GIVEN.** 

Student's Name: (First, Middle, Last):

Secondary Insurance Company: Secondary Insurance Company: Sobscriber: Sobscriber SSN: Spatient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: ONO YES Are you sick today? (vaccine will not be administered if patient is ill or has fever) NO YES Females: are you pregnant or nursing? NO YES NO YES Do you have allergies or reactions to any foods - including EGGS, medications, vaccines or latex? If Yes, list: NO YES Females: are you pregnant or nursing? NO YES Do you have a history of asthma or wheezing? NO YES Do you have a weakened immune system or close contact with a person with an extremely weakened immune system who needs special care? NO YES Are you as moker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe: NO YES Have you ever fainted or passed out after an injection?  CONSENT: I have read, or had explained to me, the attached Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccine be given to me (or the person named above for whom I am authorized to make this request). I authorize billing the insurance listed above and the release of any medical or other information necessary to process an insurance claim. I understand that RockPeds may disclose this health information to my Primary Care Provider listed above, health systems and hospitals, payment or other health care operations. I also understand that RockPeds will use and disclose my health information as set forth in the Notice of Privacy Practices, attached to this document.								
Mother/Guardian: Phone:	DOB:	SSN:Age:Gender: M F						
Father/Guardian: Phone: Primary Care Doctor/Clinic: Town: Pharmacy: Is this patient covered by insurance? YES or NO Name of insurance Company: Name of Subscriber: Security of Subscriber DOB: Subscriber SSN: Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: Secondary Insurance Company: Subscriber SSN: Patient's relationship to Subscriber: Subscriber DOB: Subscriber DOB: Subscriber DOB: Subscriber SSN: Name of Subscriber: SELF SPOUSE CHILD OTHER: SUbscriber SSN: Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: SUbscriber SSN: Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: SUbscriber SSN: Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: SUbscriber SSN: Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: SUbscriber SSN: Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: SCREENING QUESTIONS Please answer the following for the student/patient: Subscriber DOB: Subscrib	Mailing Address:		_ City:		Zip:			
Primary Care Doctor/Clinic: Town: Pharmacy:  Is this patient covered by insurance? YES or NO Name of Insurance Company: Name of Subscriber: Subscriber DOB: Subscriber SSN: Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER:  Secondary Insurance Company: Secondary Ins. ID Number: Subscriber DOB: Subscriber SSN: Patient's relationship to Subscriber DOB: Subscriber DOB: Subscriber SSN: Patient's relationship to Subscriber DOB: Subscriber SSN: Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: Subscriber DOB: Subscriber SSN: Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: Subscriber DOB: Subscriber SSN: Subscriber SSN: Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: Subscriber DOB: Subscriber SSN: Subscriber DOB: Subscriber	Mother/Guardian	:	Phone:					
Is this patient covered by insurance? YES or NO Name of Insurance Company:	Father/Guardian:							
Ins. ID Number:	Primary Care Doct	tor/Clinic : Town:		PI	narmacy:			
Group Number:	Ins. ID Number: _ Subscriber DOB: _	Group Number: Subscriber SSN:		Name	of Subscriber:			
Group Number:	Secondary Insurar	nce Company:	Se	econdary Ins.	ID Number:			
SCREENING QUESTIONS Please answer the following for the student/patient:  NO YES	Group Number: _	Name of Subscriber:		9	ubscriber DOE	3:		
NO YES Do you have allergies or reactions to any foods - including EGGS, medications, vaccines or latex? If Yes, list:	Subscriber SSN:	Patient's relationship to Subscribe	r: SELF	SPOUSE				
NO YES Do you have allergies or reactions to any foods - including EGGS, medications, vaccines or latex? If Yes, list:  NO YES Females: are you pregnant or nursing?  NO YES Have you received any vaccinations in the past 4 weeks?  NO YES Do you have a history of asthma or wheezing?  NO YES Do you have a weakened immune system or close contact with a person with an extremely weakened immune system who needs special care?  NO YES Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe:  NO YES Have you ever fainted or passed out after an injection?  CONSENT:  I have read, or had explained to me, the attached Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccine be given to me (or the person named above for whom I am authorized to make this request). I authorize billing the insurance listed above and the release of any medical or other information necessary to process an insurance claim. I understand that RockPeds may disclose this health information to my Primary Care Provider listed above, health systems and hospitals, payment or other health care operations. I also understand that RockPeds will use and disclose my health information as set forth in the Notice of Privacy Practices, attached to this document.  Signature of Parent or Guardian  Por Cunic Use Done:  NO PENNATE  Date  PRIVATE  NO PRIVATE  Date  PRIVATE  PRIVATE  DATE  PRIVATE  DATE  PRIVATE  PRIVATE  PRIVATE  DATE  PRIVATE  DATE  PRIVATE  PR	SCREENING QU	UESTIONS Please answer the following for the stud	ent/pati	ent:				
If Yes, list:  NO YES Females: are you pregnant or nursing?  NO YES Have you received any vaccinations in the past 4 weeks?  NO YES Do you have a history of asthma or wheezing?  NO YES Are you receiving long-term aspirin therapy?  NO YES Do you have a weakened immune system or close contact with a person with an extremely weakened immune system who needs special care?  NO YES Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe:  NO YES Have you ever fainted or passed out after an injection?  CONSENT:  I have read, or had explained to me, the attached Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccine be given to me (or the person named above for whom I am authorized to make this request). I authorize billing the insurance listed above and the release of any medical or other information necessary to process an insurance claim. I understand that RockPeds may disclose this health information to my Primary Care Provider listed above, health systems and hospitals, payment or other health care operations. I also understand that RockPeds will use and disclose my health information as set forth in the Notice of Privacy Practices, attached to this document.  Signature of Parent or Guardian  FOR CUNNESTRATION DATE  NOTHER DIN BY IMMUZ REGISTRY  SIATE (VFC) OR PRIVATE	$\bigcirc$ NO $\bigcirc$ YES	Are you sick today? (vaccine will not be administer	ed if pat	ient is ill o	r has fever)			
NO YES Have you received any vaccinations in the past 4 weeks?  NO YES Do you have a history of asthma or wheezing?  NO YES Are you receiving long-term aspirin therapy?  NO YES Do you have a weakened immune system or close contact with a person with an extremely weakened immune system who needs special care?  NO YES Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe:  NO YES Have you ever fainted or passed out after an injection?  CONSENT:  I have read, or had explained to me, the attached Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccine be given to me (or the person named above for whom I am authorized to make this request). I authorize billing the insurance listed above and the release of any medical or other information necessary to process an insurance claim. I understand that RockPeds may disclose this health information to my Primary Care Provider listed above, health systems and hospitals, payment or other health care operations. I also understand that RockPeds will use and disclose my health information as set forth in the Notice of Privacy Practices, attached to this document.  Signature of Parent or Guardian  Date  FOR CLUNIC USE ONLY:  ADMINISTRATION DATE:  ENTERED IN KY IMMUZ REGISTRY  ENTERED IN KY IMMUZ REGISTRY  ENTERED IN KY IMMUZ REGISTRY  STATE (VIC) OR PRIVATE	○ NO ○ YES		cluding	EGGS, med	lications, va	ccines o	r latex? 	
NO YES Do you have a history of asthma or wheezing?  NO YES Do you have a weakened immune system or close contact with a person with an extremely weakened immune system who needs special care?  NO YES Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe:  NO YES Have you ever fainted or passed out after an injection?  CONSENT:  I have read, or had explained to me, the attached Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccine be given to me (or the person named above for whom I am authorized to make this request). I authorize billing the insurance listed above and the release of any medical or other information necessary to process an insurance claim. I understand that RockPeds may disclose this health information to my Primary Care Provider listed above, health systems and hospitals, payment or other health care operations. I also understand that RockPeds will use and disclose my health information as set forth in the Notice of Privacy Practices, attached to this document.  Signature of Parent or Guardian  Date  FOR CLUNIC USE ONLY:  ADMINISTRATION DATE:  ENTREED IN KY IMMUZ REGISTRY  STATE (VFC) OR PRIVATE	$\bigcirc$ NO $\bigcirc$ YES	Females: are you pregnant or nursing?						
NO YES Are you receiving long-term aspirin therapy?  NO YES Do you have a weakened immune system or close contact with a person with an extremely weakened immune system who needs special care?  NO YES Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe:  NO YES Have you ever fainted or passed out after an injection?  CONSENT:  I have read, or had explained to me, the attached Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccine be given to me (or the person named above for whom I am authorized to make this request). I authorize billing the insurance listed above and the release of any medical or other information necessary to process an insurance claim. I understand that RockPeds may disclose this health information to my Primary Care Provider listed above, health systems and hospitals, payment or other health care operations. I also understand that RockPeds will use and disclose my health information as set forth in the Notice of Privacy Practices, attached to this document.  Signature of Parent or Guardian  Date  FOR CUNIC USE ONLY:  ADMINISTRATION DATE:  ENTERED IN KY IMMUZ REGISTRY	$\bigcirc$ NO $\bigcirc$ YES	Have you received any vaccinations in the past 4 w	eeks?					
NO YES Do you have a weakened immune system or close contact with a person with an extremely weakened immune system who needs special care?  NO YES Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe:	○ NO ○ YES	Do you have a history of asthma or wheezing?						
extremely weakened immune system who needs special care?  NO YES Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe: NO YES Have you ever fainted or passed out after an injection?  CONSENT: I have read, or had explained to me, the attached Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccine be given to me (or the person named above for whom I am authorized to make this request). I authorize billing the insurance listed above and the release of any medical or other information necessary to process an insurance claim. I understand that RockPeds may disclose this health information to my Primary Care Provider listed above, health systems and hospitals, payment or other health care operations. I also understand that RockPeds will use and disclose my health information as set forth in the Notice of Privacy Practices, attached to this document.  Signature of Parent or Guardian  Por Clunic Use ONLY:  ADMINISTRATION DATE: ENTERED IN KY IMMUZ REGISTRY  ENTERED IN KY IMMUZ REGISTRY  STATE (VFC) OR PRIVATE	○ NO ○ YES	Are you receiving long-term aspirin therapy?						
disease? If yes, please describe:	○ NO ○ YES	•		•	son with an			
CONSENT:  I have read, or had explained to me, the attached Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccine be given to me (or the person named above for whom I am authorized to make this request). I authorize billing the insurance listed above and the release of any medical or other information necessary to process an insurance claim. I understand that RockPeds may disclose this health information to my Primary Care Provider listed above, health systems and hospitals, payment or other health care operations. I also understand that RockPeds will use and disclose my health information as set forth in the Notice of Privacy Practices, attached to this document.  Signature of Parent or Guardian  Poate  FOR CLUNIC USE ONLY:  ADMINISTRATION DATE:  ENTERED IN ECW  ENTERED IN ECW  ENTERED IN ECW  ENTERED IN ECW  PRIVATE	○ NO ○ YES	•				ing		
I have read, or had explained to me, the attached Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccine be given to me (or the person named above for whom I am authorized to make this request). I authorize billing the insurance listed above and the release of any medical or other information necessary to process an insurance claim. I understand that RockPeds may disclose this health information to my Primary Care Provider listed above, health systems and hospitals, payment or other health care operations. I also understand that RockPeds will use and disclose my health information as set forth in the Notice of Privacy Practices, attached to this document.  Signature of Parent or Guardian  Port Lunic Use ONLY:  ADMINISTRATION DATE:  ENTERED IN ECW  ENTERED IN ECW  PRIVATE  STATE (VFC) OR PRIVATE	○ NO ○ YES	Have you ever fainted or passed out after an inject	ion?					
FOR CLINIC USE ONLY:  ADMINISTRATION DATE:  ENTERED IN ECW  ENTERED IN KY IMMUZ REGISTRY  STATE (VFC) OR PRIVATE	I have read, or a chance to asl vaccination as authorized to r information ne my Primary Ca understand tha	k questions, which were answered to my satisfaction described. I request that the influenza vaccine be givenake this request). I authorize billing the insurance lecessary to process an insurance claim. I understand are Provider listed above, health systems and hospitate at RockPeds will use and disclose my health informa	n, and I u ven to m isted abo that Roo Is, paym	inderstand le (or the p love and the ckPeds may lent or oth	the benefit erson name e release of / disclose th er health ca	s and rised above any med is health re opera	sks of the for whe dical or n informations. I	ne om I am other nation to also
FOR CLINIC USE ONLY:  ADMINISTRATION DATE:  ENTERED IN ECW  ENTERED IN KY IMMUZ REGISTRY  STATE (VFC) OR PRIVATE	Signature of Pa	arent or Guardian		Date	!			
ENTERED IN ECW ENTERED IN KY IMMUZ REGISTRY STATE (VFC) OR PRIVATE	_							
ENTERED IN KY IMMUZ REGISTRY STATE (VFC) OR PRIVATE	ADMINISTRATION DATE:	·						
STATE (VFC) OR PRIVATE	ENTERED IN ECW							
	ENTERED IN KY IMMUZ F	REGISTRY						
	STATE (VFC) OR PRIVA	ATE (M)		ocke:	CTI E			

