

ATTENTION PARENTS:

SCAN THE QR CODE AT THE RIGHT OR GO TO WWW.KNOX.ZIPPSLIP.COM TO COMPLETE THE CONSENT PROCESS ON-LINE
 Or, if you don't want to complete the consent process on-line, please complete this form and return it to your child's homeroom teacher. **Please do not do both.**



KNOX COUNTY HEALTH DEPARTMENT

**STUDENT CONSENT FORM and Live Attenuated
 Influenza Vaccine / Inactivated Influenza Vaccine
 Immunization Nursing Record
 School-Located Vaccination Clinics (SLVC) 2011**

SCHOOL: _____

HOME ROOM TEACHER: _____

GRADE: _____ AGE: _____ DOB: ____/____/____

GENDER: Male Female

PLEASE PRINT Child's Name - First: _____ MI: _____ Last: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: () _____ - _____ Cell Phone: () _____ - _____ Emergency Number: () _____ - _____

Email: _____ Child's Pediatrician: _____

Mother's Name: _____ Father's Name: _____

Guardian, if under 18 - Name: _____ Relationship: _____

Primary Language: _____ Hispanic: Yes No

Race: White Black Asian American Indian Alaskan Native Other: _____

Insurance: TennCare No Insurance Private Insurance (but does not cover flu) Private Insurance

Insurance Name: _____ Member ID: _____ Group ID: _____

Please answer NO or YES to the questions below.

The questions are answered for the person receiving the vaccination.

Please **Circle**
for each
question

1. Is this the first time your child will be vaccinated with flu vaccine?	No	Yes
2. Was your child vaccinated for the first time last year with Seasonal flu vaccine? If yes how many doses? _____	No	Yes
3. Has your child received a vaccine within the past 30 days? Name of Vaccine(s): _____	No	Yes
4. Has your child ever had a severe (life threatening) allergic reaction to the flu vaccine?	No	Yes
5. Does your child have any of the following: - chronic heart diseases - diabetes or other metabolic diseases/disorders - kidney diseases - blood diseases - asthma	No	Yes
6. Is your child allergic to vaccine components, i.e. eggs, gentamicin sulfate, MSG?	No	Yes
7. Is your child pregnant or nursing?	No	Yes
8. Has your child ever had Guillain-Barre' syndrome?	No	Yes
9. Is your child under 18 years of age and on long-term aspirin therapy?	No	Yes
10. Does your child have a disease such as cancer, lupus, HIV/AIDS, or take a medication that lowers the body's resistance to infection?	No	Yes
11. Does your child have close contact with anyone who has had a bone marrow transplant in the last 6 months?	No	Yes

Request for Administration of Influenza Vaccine for the above named recipient: I am aware that the receiver of this vaccine is currently not pregnant nor will become pregnant within four weeks of receiving this vaccine. 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.

Parent / Guardian Signature

Date

(Consent form is valid 6 months from date of initial signature)

Official Use Only

____ VFC ____ 317 ____ PAY ____ TIV ____ LAIV	Phase One			
	Mfr/Lot: _____	Expiration: _____	Date Given: _____	Amount: _____ VIS Date: _____
	Route: _____	Site: _____	Signature: _____	Provider ID: _____
____ VFC ____ 317 ____ PAY ____ TIV ____ LAIV	Phase Two			
	Mfr/Lot: _____	Expiration: _____	Date Given: _____	Amount: _____ VIS Date: _____
	Route: _____	Site: _____	Signature: _____	Provider ID: _____